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AUTHOR Melcer, Donald; And Others
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ABSTRACT

This is a report of the therapeutic unit developed under the auspices of Head Start for the education of atypical low income children who cannot be contained in regular Head Start classrooms. The primary objective for this first year descriptive phase was to determine if the teaching staff could work productively with six pupils who presented a wide range of clinical, family and learning problems. The staff included a head teacher, an aide, a volunteer (none of whom had special education training), and a clinical psychologist. The program was organized around 3 structural groupings: (1) total group activities, to create group cohesion and improve social skills; (2) sub-group activities, designed around level of motor abilities and communication skills; and (3) individual therapy, for perceptual-motor development, communication skills, social and emotional problems. Parent involvement and home visits were integral parts of the program. It was concluded that the staff worked effectively with the children since all children improved to some degree in the basic skill. Nearly all the parents were able to change their attitudes and behavior towards their atypical child. The document includes details of staff roles, case studies, classroom settings, meals, follow-up activities, and future placement information. (Author/AJ)

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Early Childhood Research Center

INSTITUTE FOR FAMILY AND CHILD RESEARCH

Year-End Report
October 1970

AN EXPERIMENTAL THERAPEUTIC PROGRAM

FOR HEAD START CHILDREN

Donald Melcer
Mary Fritz
Mary-Clare Boroughs

PS 005087

COLLEGE OF HUMAN ECOLOGY

MICHIGAN STATE UNIVERSITY

Robert P. Boger, Director

Donald Melcer, Associate Director

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THERAPEUTIC TRAINING MODULE

Abstract

A therapeutic unit was developed by the Michigan State University Head Start Research Center for the education of low-income children who could not be contained in the regular Head Start classrooms. Head Start guidelines encourage inclusion of atypical children; however, no provisions were made to meet their special educational, emotional, and developmental needs. This unit was designed to simulate conditions found in typical Head Start programs. Pupils were selected who presented a wide range of clinical, family, and learning problems. The teaching staff was composed of a head teacher, aide, and volunteer, none of whom had received training in psychology or special education. Professional consultation consisted of ten hours per week by a clinical psychologist. The prime task for the first year descriptive phase of the program was to find out if the teaching staff could work productively with a diverse group of atypical pupils.

Program Need

The need for a therapeutic Head Start program was established by a survey of Head Start teachers conducted in the spring of 1969. The survey covered four behavioral areas which indicate possible emotional or perceptual disabilities in young children. It was also designed to prevent teachers from over identifying pupils. Teachers identified approximately 20% of their pupils as having possible perceptual-motor or emotional difficulties. They believed that about half of those children identified needed additional attention which they could not provide in class due to

either their lack of knowledge about the problems, or the sheer lack of time needed to meet these children's needs. For the other half of the identified children, teachers felt they could deal with their problems in context of their classroom with professional consultation plus perhaps the additional assistance of a volunteer or aide.

Educational Model

The psychopedagogical model for instruction was selected for this program. "The Psychopedagogical Model... combines the clinically processed theories and techniques, with the school processed concepts and methods of teaching. Its major tool is the total curriculum rather than particular intervention, as is true in the case of either the older clinical therapies or the Behavior Modification and Social Competence technology."[1]

Pupil Selection

Five pupils were selected for the pilot program who exhibited a wide range of personality, developmental, and learning problems. Later a sixth child who had been diagnosed as autistic was added on a half-time participation basis. The symptoms and problems of the original group included speech and communication difficulties, minimal neurological damage, withdrawal, aggression, immature emotional development, and hyperactivity. Two children were on drug therapy (Ritalin) when accepted. In addition to the wide range of symptoms displayed by the group, two

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[1]Rhodes, W. C. In J. Helmuth (Ed.) Educational Therapy, Vol. 1. Seattle: Special Child Publications, 1966.

levels of social competency were evident within the first few weeks. By chance the boys were more socially competent than the girls, and were able to function in relatively elaborate group activities.

Program Description

The program was organized around three structural groupings (1) total group activities (2) sub-group activities, and (3) individual therapy and instruction. Total group activities were designed for the purpose of creating group cohesion and identity and for improving basic social skills of the pupils. These activities included rhythm and music games, group plays, outdoor activities, and lunch time. Sub-group activities were designed around levels of motor ability and communication skills of the pupils. Female pupils were much lower in both these skills than boys -- probably by chance in this small group -- and the group was divided for one period each day for instructional activities appropriate to ability levels of each group. Finally, individual instructional schedules were developed for each child according to specific needs in areas of perceptual motor development, communication skills, and social and emotional problems. Activities ranged from the use of special education materials for a mildly neurologically involved child, to play therapy for an aggressive disturbed child.

Parent Involvement

Parent involvement is an integral part of the program. We are convinced that the power of the influence of the family system is so great as to invalidate any gains that may be made by the child in the therapeutic unit. Thus, family intervention is seen as another major

goal of therapeutic education. This year we established a working relation with every family through home visits by the teacher and psychologist. Parents came to the unit and observed their children from behind a one-way screen. We attempted to modify parent's attitude and behavior toward their child. Next year we intend to intensify this work through the use of a micro-teaching model. By a combined use of a systems approach to understanding the family, i.e., communication patterns, dynamics, etc., and micro-teaching for parents, we hope to produce a restructuring of the family system in relation to the atypical child.

Evaluation

To date we have used the case study approach describing gains in (1) language development (2) communication skills (3) perceptual-motor development (4) social development, and (5) intellectual development. Since all children were untestable by most standard instruments, we could use only clinical indices of gain in these areas.

Results

All children in the program improved to some degree in the categories mentioned above. The most dramatic changes were in the areas of communication and social skills. Further, the two children who were receiving drug therapy were removed from drugs during the program and showed no evidence of needing drugs afterward. In both cases the psychotherapeutic effect of the program seemed evident since both were emotionally disturbed children upon enrollment. Moreover, the parents -- in all cases but one -- were able to change their attitude and behavior toward

their atypical child. Generally speaking, they were able to accept more realistically their child's problem and learned effective ways of guiding their child at home.

Perhaps the most significant result of this first year's work was that the teaching staff was able to work effectively with a group of children who presented a wide variety and degree of emotional and developmental problems. Recall that none of the pupils could be contained in a regular preschool program, and that none of the staff had received training in psychology or special education. Professional assistance consisted of ten hours per week consultation by a clinical psychologist. This combination of teaching and consulting staff -- apparently a minimal team for providing an appropriate educational program for atypical children -- could be assembled for most Head Start programs. Thus, the practicality of therapeutic Head Start education was demonstrated.

ACKNOWLEDGEMENTS

The initial year of any project is an especially exciting time because it marks the realization of ideas that have usually been years in the formulating and planning stages. This project came dangerously close to not being realized, even after careful planning, due to unforeseen problems in locating atypical Head Start eligible children through the local Head Start program. Thus we are especially grateful to a number of people representing several community agencies who came to our rescue in referring low-income children with special problems to us. We wish to thank Maurine Robinson, School Nurse, Lansing School District; Luttie Papesh, School Diagnostician, Beekman Center; Jean Waldo, MSU Speech and Hearing Clinic; Mary Kay Hunter, St. Lawrence Community Mental Health Center; Don Dosey, Social Worker, Lansing Head Start, and; Dr. Lucy Ferguson, Director, MSU Psychological Clinic. We are particularly indebted to the children who were our pupils and their families for participating in the program. We also wish to thank Ann Peters, teacher aide, and Sally Meuhlenbeck, volunteer, for their willingness to adapt to the unusual demands of therapeutic education. And, once again, we have the opportunity to thank our office staff, Theresa Mitroka, Alice Lucas and Joanne Clason, for their fine work in correcting our errors, and typing and producing another report.

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Therapeutic Training Module

Donald Melcer, Coordinator
Mary Fritz, Teacher
Mary-Clare Boroughs, Psychologist

Head Start Guidelines specifically encourage "the inclusion of mentally or physically handicapped preschool children in programs which also serve the non-handicapped" (Head Start Manual, Sept. 1967, p. 5). The Guidelines do not state how the children are to be identified and educated, however. Certainly, it is well accepted that mentally and physically handicapped children need special kinds of education and treatment, and therefore some provisions need to be made for them over and above those specified for usual Head Start pupils.

An especially complex problem is that of identification of handicapped children. Even with extensive psychological and neurological examinations, it is exceedingly difficult to draw the categorical line between handicapped and non-handicapped disadvantaged children at the Head Start age level. Therefore, the purpose of this study is twofold: to develop screening techniques to help Head Start teachers identify children who may be mentally or physically handicapped and begin a pilot program for the therapeutic education of children so identified.

Concept of the Therapeutic Preschool

Therapeutic preschool for children with mental or physical handicaps is a relatively recent development, although its origins stem from earlier forms of treatment of childhood disabilities. Historically, programs for physically handicapped children derive from the medical treatment model, while programs for emotionally disturbed children trace their beginnings

to the psychoanalytical model. By the late nineteen-forties it had become accepted generally that the earlier corrective treatments were begun for children with either type of problem, the greater would be the results. Additionally, evidence of learning difficulties often concommitant to both conditions began to accumulate. Thus, in the early fifties there was rapid and widespread proliferation of centers for the education and treatment of handicapped children. During this growth period, specific disabilities usually were separated formally into physical or mental handicaps. Practitioners soon discovered, however, that there is so much commonality of symptoms as to make the procedure of categorical diagnoses highly judgmental at best. Dubnoff (1966) criticized the medical diagnosis model as a basis for therapeutic education and stated that, "In our school we find that usually structure and function are interrelated, and education can proceed in the absence of definite diagnosis." Thus, it is becoming more and more accepted that therapeutic preschool can precede diagnoses, and that in fact, more accurate diagnoses can be made by extended observation of a child in the school setting.

Rhodes (1966) discusses the several models of therapeutic education that have evolved during the period from the early fifties to the present. These are the Social Competence Model, the Behavior Modification Model, and the Psychopedagogical Model. All have in common the application of predesigned experiences to alter the behavior of the child. Inherent in the philosophy behind all three models is that children with special problems can be helped to blossom and flourish, and indeed, many can become a part of the "normal" population as a result of a program of therapeutic education.

The psychopedagogical model was chosen for this project because it appears to be more consistent with personnel resources and educational programs typically found in Head Start preschool systems. Rhodes (op. cit.) describes the model as follows:

> "The Psychopedagogical model is like the clinical model and different from the Social Competence or the Behavior Modification model in the degree of emphasis which is put upon human relationship as a major modality for development. The person of the teacher, like the person of the therapist, is considered a dominant influence in the growth producing exchange..... Psychopedagogy looks upon the curriculum as the predominant influence, but sees the quality of the encounter as a deciding factor in the curriculum's effect upon the child."

One problem, though, has plagued the effectivness of all models. This is the problem of the powerful and continual influence of the family on the child's behavior and learning. None of the models above specifically include family structure and dynamics as a critical variable to be dealt with in educating the child. Thus, a newer concept of therapeutic preschool is now emerging which recognizes that the family is the child's primary social and learning unit and must be incorporated within the educational model as a major input. By and large, however, present intervention programs still tend to focus primarily either on the family or on the child in school.

The model which is proposed for this project integrates the Psychopedagogical preschool and parent education models. To our knowledge, it will be the first program which attempts to alter the environment of the child's primary and secondary social groups simultaneously. Experience has made it clear that change agents must be active cooperatively in both areas of a handicapped child's life if significant and permanent improvements are to be expected.

First Year Tasks

The major task for the initial year of the Therapeutic Head Start Unit is to simulate as closely as possible resources and conditions typical of Head Start systems and to find out if therapeutic education is workable under such conditions. Invariably one of the temptations in a University based facility is to utilize the abundant personnel and consulting resources available, but which are often in critically short supply in normal community Head Start operations. Another temptation in the research area is to spend amounts for equipment and services that would be prohibitively expensive in regular programs. We attempted to avoid both and design the program pragmatically with the goal of eventually producing a workable, exportable "curriculum module" for the therapeutic education of atypical Head Start pupils.

The criteria for selecting staff, pupils, and material resources, therefore, were that all would be a reasonable approximation of conditions found in Head Start systems. A head teacher was chosen who had proven herself to be an excellent teacher of normal children, but who had received no special training in working with atypical children. A clinical psychologist was selected who had had experience with Head Start programs but who could devote only one-quarter time to the project. The teacher aide had no Head Start experience nor formal teacher training, but had worked with poverty stricken adults and children in the Peace Corps. Pupils were selected who exhibited a great variety of symptoms from hyperactive to withdrawing behavior together with every level of speech and language problems. Finally, the budget for play equipment and

educational materials was minimal, and certainly within reach for any Head Start program.

The report to follow is a narrative of the development and operation of the program. It was written by Mrs. Mary Fritz, Head Teacher, and Mrs. Mary-Clare Boroughs, Psychologist, and is presented with only minor editorial revisions. As such it is not a typical research report with a comparative design, nor pre- and post-treatment evaluations. These were not purposes of the project. Rather, it presents in detail the problems encountered in establishing a therapeutic program and dealing with the psycho-educational problems of a very diverse group of atypical children. The reader will note how a skilled teacher and psychologist combined their respective talents to produce the many educational innovations necessary for the program to operate successfully. The report, therefore, constitutes something of a case study in itself of the problems a professional staff encounters in entering "unknown territory" and the solutions they developed for solving the problems encountered.

From a research standpoint, the question was rather simple. Can handicapped children, who cannot be contained or educated in a regular Head Start classroom, be habilitated and educated in a psychotherapeutically oriented classroom? The first level of this question can be answered by the case study method. If affirmed, then consideration can be given to the need for differentiating the question and developing comparative research designs.

Donald Melcer
August 1970

PS 005087

Introduction

The development of the Therapeutic Head Start unit began in August, 1969 as a response to the needs expressed by Head Start teachers in a 1968-69 project. These teachers identified an average of three pupils in every thirty whose problems were beyond the scope of classroom services and procedures and a like number who needed special services, but who, the teachers felt, could be helped within the usual class situation. The purpose of the research unit was twofold:

1. To develop screening techniques to help Head Start teachers identify children who have special problems requiring specialized treatment, children who are atypical in physical, intellectual or emotional development, and

2. To develop a program for the therapeutic education of children so identified.

Originally, arrangements had been made with the Lansing Head Start program to use the screening methods for pupil identification and to develop a therapeutic unit as an adjunct to their program. However, after a considerable delay, the Director of the Lansing program asked us to withdraw our therapeutic program due to a conflict with a teacher-training project operated by another Head Start agency.

We then continued to search for a way to serve as a direct Head Start service. An attempt was made to contact families on the Head Start waiting list to find children who might be eligible for the therapeutic unit. This method proved unproductive since there was no way in this context to accomplish preliminary screening.

The final resolution of the recruitment problem was to contact local mental health agencies and other specialized services for referral

of low income preschool age children who had been identified as needing therapeutic education. Referrals from this source were screened by our psychologist and teacher, and the unit began operation in mid-January, 1970, with three children. By the end of the month two more children were accepted, bringing the enrollment up to the maximum of five children. Later in the year, a sixth child was added on a part-time basis.

Staff Roles

Selection of staff for the therapeutic unit was determined by the needs for an experimental program for atypical Head Start children with the practical considerations of eventually producing a model program that could be operated in the context of Head Start education. A high level of professional expertise was needed for development and evaluation, while at the same time it seemed essential to operate the daily program of therapeutic education with people who were qualified to teach and work with young children, but had no special training in special education or clinical psychology.

The unit coordinator was Dr. Donald Melcer, who worked with an advisory panel on matters of policy decision. Members of this panel are Dr. Robert Boger, Director, Institute for Family and Child Research; Dr. Lucy Ferguson, Director, Michigan State University Psychological Clinic; and Dr. Frank Bruno, Coordinator, Program for Emotionally Disturbed Children, Department of Special Education. This panel provided no direct services to the unit, but was concerned mainly with the teaching and research potential of the program.

The program psychologist was Mary-Clare Boroughs, a Ph.D. candidate

in clinical psychology. Her special qualifications included experience as a school diagnostician, and as mental health consultant to three Head Start classes. Mary Fritz, M.A., was the head teacher for the unit. Last year Mary was a teacher in the Michigan State University Laboratory Preschool. She was selected for our program because she had received no special training for working with disturbed or handicapped children, but was an effective teacher with young children. She had that certain sensitivity with problem children which is hard to define but very apparent to observation.

Anne Peters served as the teacher aide in the unit. Anne has a degree in English, but no formal training in either teaching, psychology or special education. She was able to communicate honestly and directly and we felt she would be able to describe the problems and feelings that working with problem children posed to an untrained person. In addition to Anne, the teacher had the service of Sally Muehlenbeck, a full-time volunteer for a two-month period after the opening of the unit. Sally was a sensitive teenager who contributed much to the children with her artistic talent and loving personality.

The problem posed in selecting a teaching staff not trained for work with atypical children was whether or not they could work effectively in a therapeutic educational setting. It is probable that most Head Start programs who initiate a therapeutic unit would have to operate with a teaching staff similar to ours. Thus, the staff question was seen as one of the most critical in this venture. In its day-to-day operation, the staff functioned as follows:

Mary Fritz planned food and curriculum, shopped for supplies,

directed the assistant teacher and volunteer, and spent the four full days with the children. In addition she made most parent contact with one parent and she visited all homes one or more times. She was also responsible for contact with two students who studied the unit for academic credit.

Mary-Clare Boroughs generally spent two days each week with the unit. The first was used to observe the children, talk with visitors who were working with the children in some other capacity, and consult with the teacher about child needs, parent programs and other staff matters. The second day was spent directly with the mothers on their visits to school.

Anne Peters and Sally Muehlenbeck took turns going to and from school on the bus. Anne worked directly with the children for most of the day as assigned by the teacher. She was responsible for meal preparation and cleanup, and for part of classroom preparation to meet day-by-day needs. Sally assisted Anne before and after class time and worked directly with the children during the full four days.

During most of the school day there were six children with three or perhaps only two adults. We believe that in order to have an intensive therapeutic program, there must be three adults present to meet the needs of the children. During the freer times of the day, two are usually sufficient, although even then, one or more children may require one-to-one attention if the activity is to continue. This is one reason why it is difficult for a regular teacher to provide therapeutic education in a class of 16 with a minimum staff.

Original plans called for brief daily staff meetings at which current needs could be discussed. While we now view at least weekly meetings as

imperative for the effective functioning of the staff, they were very difficult to accomplish because of the schedule. Mary Fritz was employed only half-time and while she and Mary-Clare Boroughs were able to hold a two-hour conference each week, the aides were riding the bus to and from school and were unable to participate. Therefore much of the contact between the teacher and aide was done in brief moments before and after school. Generally it was necessary to deal with immediate plans for the day and necessary variations in the schedule at these short meetings.

In undertaking a similar project, a Head Start system should recognize the tremendous emotional drains on the staff of a therapeutic program, particularly in the early stages. The successful operation of our classroom rested largely on the supportive trust and rapport between the teacher and the psychologist. Their relationship was honest and relaxed, and there were no strict lines drawn between their professional roles. For example, one child's mother seemed to need frequent reassurances in the form of detailed reports of her child's classroom behavior, so the teacher regularly called her. However, the psychologist made the contacts with the child's former therapist. Likewise, while the psychologist did not function in the classroom as a fellow teacher, she was often present with the children during transition periods. She also helped the teacher plan curriculum. The teacher and psychologist kept each other fully informed about progress of the children in school and at home so that each one was always aware of the latest developments in both processes. It was crucial to successful classroom teaching that the teacher had the supportive relationship with the psychologist. For any similar program, a supportive professional such as a school principal,

social worker, or fellow teacher must be available to work with the teacher of a therapeutic classroom in a personal, helpful way.

We feel that it was particularly significant that the psychologist and teacher had these sources of strength:

1. Secure and vigorous families of their own who provided support and relief from a demanding job.

2. Previous experience with the frustrations and day-to-day emergencies of working with preschool programs, particularly Head Start.

3. Firm philosophical commitment to the importance of working with these children and their families.

While the psychologist and teacher were able to encourage and support each other, the aides did not regularly have this same outlet for feelings. We feel that the staff members with less professional training are more vulnerable to emotional frustration on the job. Therefore the aide and volunteer were caught in the double bind of needing more supportive communication from fellow staff members and receiving less of it. For this reason we would recommend regular meetings with aides for dealing with these problems.

Three problems in particular might have been alleviated through regular "blow off" meetings. The first was the non-professional staff's inability to recognize their own negative emotional reaction to a child. Teachers naturally react differently to their pupils, and an experienced professional has learned to recognize her negative reactions to a child, done some soul-searching to understand why she feels that way, and attempted to re-work her attitude. This human relations problem is especially significant when working with disturbed children since they usually exhibit behaviors that others may find distasteful (e.g., clinging

incompetence, animal-like withdrawal). For untrained staff who are not familiar with some of the meaning of such behavior, their emotional reactions can interfere with effective teaching. We felt that our children were more sensitive to these emotional feelings of our staff than a more normal population might be. Thus one boy, with little ego strength of his own, showed great distrust of a staff member who found it difficult to establish and enforce limits for him. Another displayed more stubbornness with a staff member whose fierce independence made it hard for her to accept his charming dependence on adults. Such problems arise in any preschool setting, but they seemed particularly important to us because of the intensity of the children's problems.

For physical and psychological relief it seemed important for the teaching staff to share the responsibility for each child. After a vigorous hour of sliding and jumping with one active girl, it was a relief to share a verbal, imaginative hour block-building with the boys. Another problem with untrained staff arose here. The boys as a group were more challenging to the teachers in a curriculum sense. They each were closer to normal four-year-old skills than were the girls and demanded more curriculum materials, effectively used. Since we did not have regular staff meetings and the disjointed room arrangements made the opportunity for team or demonstration teaching rare, the aides often felt that they lacked the skills to teach the boys effectively. They expressed such simple concerns as not knowing how to effectively introduce new materials and hold the children's attention. Teaching with the girls was apt to be less complicated in materials and techniques, but their patterns of response were in some ways less satisfying to the teacher as a steady

experience. Given adequate time for staff meetings, the teacher could do more demonstration and discussion of specific preschool curriculum materials and methods.

A second problem which closer communication might have helped was a tendency to blame the parents entirely for their children's problems. We have observed that new teachers are apt to be possessive with their pupils and find it difficult to share the educational task with parents. That separation is apt to result in each side blaming the other for the child's problems, particularly for the atypical child. The aides had no children of their own and the six pupils we had, therefore, became extremely important to them. Feeling possessive and pained by the children's pain, it was easy for them to want to blame the parents instead of understanding the dynamics of the children's lives. Since the parents themselves often feel a bit defensive and vulnerable because their child must be placed in such a program, there are many small opportunities for poor communication on both sides. It seems important to help staff members think about themselves and their own experiences in families which may lead to greater understanding of the families we work with.

A third and final problem which seems linked to communication is the hopeless feeling that the children have changed really very little. Inexperienced teachers do not see how slightly and slowly a preschooler seems to change within any school. Particularly when they have a strong emotional reaction to a child, there is a great wish for him to change dramatically; perhaps partly as validation for teaching effort. One result of this hopelessness and worry was a kind of desperate bearing down, an "I'll make him change!" attitude which naturally interfered with

sound teaching. With our particular group, one source of relief and encouragement was a resultant of the variety and severity of the children's maladjustments. When one child seemed to be stalemated, another might be showing encouraging progress.

In sum, Head Start therapeutic programs, by necessity, must depend upon untrained teacher aides and volunteers. First, these personnel must be screened with utmost care to find individuals with potential for working with disturbed children. But the process can't stop there. An active in-service training program must be provided to help the volunteers and aides learn to recognize their own emotional reactions to atypical children. Certainly disturbed children generate powerful emotional reactions in the adults working with them; from intense pity at one extreme to anger and fury at the other. Yet the adult has the responsibility of responding to the child in a constructive way at all times. The child gains nothing when an adult pities him or vents anger upon him. Thus, the program has the responsibility for helping the nonprofessional staff deal with the negative emotions generated in their work with children.

Referral Sources

The five full-time pupils represented a variety of referral sources. Two were referred by traditional mental health clinics. In one case, the child had been seen weekly at the clinic. The mother was participating in group psychotherapy, and had received individual therapy previously. During the year she became eligible for social welfare aid (ADC). In the other case, the child had been seen three to five times weekly in individual

psychotherapy and both parents were in therapy as well.

A school nurse assigned with a special team to poverty area schools referred a third child to us. In this child's family, an older sibling had required special arrangements the year before when she entered school, and this second child was perceived as having related problems. The older child now appears to continue to have learning problems and to need long-range treatment plans.

The fourth child was referred to us by the Beekman Center, a county-based facility for trainable retarded children and adults. The staff there felt they could no longer justify the inclusion of this child in their home care program when she did not appear to be sufficiently retarded to be eligible for class placement. At our request she was assessed by the local public school program for the physically handicapped. She has been diagnosed as being mildly cerebral palsied, but she was not considered sufficiently handicapped to warrant special classroom placement on that account.

The Michigan State University Speech and Hearing Clinic referred a fifth child to us who had been in treatment at their clinic for one year. She had been seen two to three hours a week during that period in combined individual and group speech therapy. This therapy continued. Her mother also met there with a mother's group staffed by student social workers. This family also received ADC.

A sixth child attended classes part-time three days a week after the program was well under way. This child was being seen at the Michigan State University Psychological Clinic where our staff psychologist was co-therapist. She had also been assessed at Beekman Center and attended

class briefly there. She was dropped from the class there because they could not provide the close attention and supervision they felt she needed.

The sources for our children have been spelled out at this length for two reasons. First, we were not able to serve children enrolled in the local Head Start program and as an alternative chose children from low income families who had been identified by reliable sources as having emotional and physiological problems. Secondly, as we worked with many community agencies in locating our pupils we became aware that other members of many of the children's families were receiving a variety of community services at considerable cost to local, state and federal agencies. Therapeutic preschool education therefore should be considered in light of its potential as a preventative service.

The Children

In our final full-time group we had five four year-old children: three boys and two girls. All came from lower income brackets. Three children were from two parent families and the other two were without fathers.

The five children represented five different types of problems, although behavior overlapped in some areas. The five behavior syndromes were the following:

1. The dependent clinging child - fearful, slow to take part, silent, possibly manipulative.

2. The non-verbal child - (in extreme) - only just beginning to talk, fearful of change, and not able to understand many verbal explanations.

3. The poorly coordinated child - (mildly cerebral palsied) - difficulty with stairs and spoon, trips frequently, also tends to echo speech (no speech impediment).

4. The aggressive, destructive child - exuberant, defiant, aggressive, destructive and angry at home.

5. The "immature" child - low self-concept, very short attention span, immature play, although apparently capable of more. (While the immature child does not usually appear to be a severe behavior problem in early years, this behavior has been found to be predictive of later academic and emotional problems and referrals to clinical services.)

The child who attended on a part-time basis was a child who had been tentatively diagnosed as autistic. She has almost no speech and withdrew to herself much of the time. Additionally her behavioral mannerisms were typical of autistic children.

Although three of these children were more atypical than we had originally envisioned for our group, there is no reason to believe that such children might not be enrolled in a comprehensive Head Start program. The more normal children were able to gain from the broader educational aspects of the program, and they contributed much to the others. They seemed to enjoy being with each other in spite of their wide ability differences, and there were no signs that any child suffered from the behavior of any other child. We were able to schedule activities in an individualized fashion to meet the needs of each child, and no child was held back by another.

One problem did arise in this regard, however. Mothers of the more normal children were somewhat distressed by the behavior of one or more of the other children. We were able to deal with this problem by discussion with the individual mothers involved. In the future it might be possible to take preventative steps in our initial orientation of mothers of the program.

The girls in this group presented more severe problems than the boys. The boys were moderately atypical. All three were verbal even though one did not talk to us. The girls were very atypical and all three had severe communication and language problems. This could have been an artifact of the group size or referral procedures, however the character of the problems in next year's referrals presents the same contrast. Also of interest is that the ratio of identified problem boys to problem girls at elementary school ages is somewhere above 5:1; but in contrast our referrals have been 1:1 or even 1:2. Apparently the perception of need and eligibility for special help could be different for boys than for girls, and is possibly different in preschool than in elementary years.

Case Studies

Each pupil will be described in this section. The studies will present material from the referral source; goals for the child in the therapeutic unit; major methods used to induce change with resultant changes in behavior, and; diagnostic impressions, together with some information about the parents.

Case One. Marvin,* a hyperactive child, is the son of a family in crisis. His father was ordered from the home in January after an extremely violent episode which climaxed a history of brutality toward the mother. The divorce was to be finalized shortly after the end of the school year. The father's failure to produce child-support made it necessary for the mother to apply for Social Welfare in March. In addition to the disorganizing effect of his family situation, Marvin's history of prematurity and early hyperactivity indicated that he may have

* Real names have not been used.

already been a hyperkinetic child. He was taking Ritalin regularly for this problem when he started school. Both the child and his mother had been seen for some months at a local mental health clinic for her needs and for his problems of aggressive and destructive behavior, and night terrors.

Major goals for this child were:

1. Self Control. Marvin clearly needed help to accept rules and to manage his behavior.

2. Therapeutic release of anger. This child had difficulty with repressed anger which he expressed through violent behavior and uncontrolled swearing at home. In accordance with the clinical goals, we sought ways to help him consciously release anger in more constructive ways in school and in ways that could also serve him at home.

3. Challenge. Marvin was an eager bright child who was much excited by his natural environment. We wanted to challenge his abilities.

The management of Marvin's behavior in school did not prove to be difficult. In the early stages his activities were supervised well enough to prevent loss of control by channeling energies into new activities. Later he was able to work with a small group with only minimal supervision. At all times rules were made specific and consistent -- as they were for all the children. After three weeks of school Marvin stopped taking Ritalin on a regular basis.

Specific methods were encouraged for anger release. For example, on a day when Marvin had come to school angry with his mother, his feelings were accepted at the start of the day; but later he was asked to beat the drum showing the sound of anger. When Marvin got mad at another child and attempted to hit him, the teacher reflected feelings saying such things as, "I can tell that makes you very angry, but you

cannot hit Steve. Let's go punch the punching bag." Vigorous activities were encouraged, but for Marvin they had to be scheduled in the latter part of the morning so he could regain composure during outdoor play. In other words, he could not be expected to go from vigorous to quiet activities. Toward the end of the year Marvin became increasingly expressive and explicit about his feelings. His verbal expression was sometimes accompanied by symptoms of distress and anxiety. At this point we were able to deal with his anxiety verbally rather than by directing him to act out his feelings. As a follow-up to preschool, we recommended that he be seen in play therapy by his former therapist, at least through the summer, to allow him continued release of pent-up concerns.

The activities of our setting in themselves offered Marvin the opportunity for challenge, since many activities could be experienced at different levels by different children. Block-building, for example, afforded him a chance to plan and construct elaborate buildings. In addition, the staff made an effort to engage him in conversation -- about his play or about the natural surroundings -- that encouraged thought about his part. All the children joined in several trips to the nearby botanical gardens, but it was Marvin who had the greatest interest in seeds, flowers, and living things.

During the last month of school, Marvin's concerns about his father surfaced and a fourth goal was added for him -- to provide a positive therapeutic relationship with a male figure. This was made possible on a once-a-week basis by the volunteer help of a male college student named David Smith, who had already shown natural ability in child therapy.

During their first meeting, an outdoor get-acquainted free period, Marvin became aggressive and uncontrolled toward David in a somewhat playful spirit. On the second occasion, Marvin tested his new adult friend with many negative statements such as "I don't like you," at the same time he was cutting up male paperdolls. (After this session his mother reported an increase in nightmares.) On the third occasion more neutral activity was planned and Marvin stood by Dave, interacting in a friendly manner. The interaction was handled well, and Marvin's mother reported the next week that Marvin had formed a close tie with his grandfather for the first time -- much to their mutual benefit!

Judging from what we learned about him, Marvin appeared to us to be a child with some tendencies to hyperactivity who had emotional problems stemming from the years of conflict in his family: from his mother's insecurity in the crisis of this year, and in particular from the final violent episode before his father left in which the father loaded a gun and threatened to shoot Marvin and his mother.

Marvin's mother was struggling with her own conflicts in the situation leading up to the divorce. Initially, she was very unsure of herself with Marvin and much of his activity seemed to be anger directed at her. She became more confident during our contact with her, and while Marvin's behavior problems continued to some degree, she had several conversations with him in which he revealed the depth of his conflicts and fears about his father. This shifted her perspective and also aided us in ways to help him better.

Perhaps because the problems arose out of a family crisis, our work with Marvin and his mother was an example of a very closely knit thera-

peutic effort. Each week -- and at times almost daily -- the mother, teacher, and psychologist exchanged observations and insights. Marvin's mother worked with her son at school and their interaction was later discussed. It was also possible to support her individually in her progress in the therapy group at the mental health clinic. The net outcome was to help this mother and child overcome a severe family crisis and to develop skills for future development.

Case Two. Steve is a boy who reportedly had no problems until he was almost three years old, when he became aggressive, hyperactive, and panicky under stress. He began daily individual therapy at a local mental health clinic when he was three. Drug therapy (Ritalin) was also started at that time. Initially, he was extremely dependent on his mother at the clinic, but made progress in his ability to separate from her and to engage in play therapy, although he never spoke directly to the therapist. In regard to our program, his therapist predicted that he would resist coming, refuse to participate, and cry uncontrollably in the early weeks.

There was one major goal for this child: to help him deal with his fears and to find pleasure in individual interaction and group participation. Separation anxiety was the main initial problem encountered in orienting Steve to preschool.

Although we bussed most children, Steve would come to school only with his mother. Finally, after many intermediate steps, he came with his teacher on the bus. He cried frantically at each new step of the way. After he began tentatively relating with other children, first with one other child, and then with the group, he found it very difficult to

part with his outdoor clothes or from any small toy he might have in his hands. We were lenient toward these "comforters" but we carefully did not give him special attention when he chose to withdraw from the group.

Very soon Steve played more freely with the boys outdoors. In about six weeks he began to join the other two boys in block play with the aide, and then with the teacher. At this time we carefully planned block play, and soon other favorite activities, in such a way that he would participate. We "opened the door" for him by planned increments. Later we arranged to promote some play with one of the other boys away from school during the spring vacation. This was most effective. At our recommendation Ritalin was discontinued in April.

The final barrier for Steve was eating with the group. At snack and lunch times he simply stood against the wall and watched the other people eat. Thus we began not with regular food times, but by setting up special "play-eating" situations. Several outdoor "picnics" were planned with Steve's favorite food and company. First he joined the group, and later ate part of a lunch. After this breakthrough, he was then able to eat indoors with his special friend behind a screen in the dining area. Later another boy was added to this special group, and finally the screen separating them from everyone else was removed. Now a part of the group, Steve was seated at the end of the table flanked by two friends. By the end of the four and one-half month period he was able to eat with a stranger present at the table.

In addition to our part in arranging activities for him, Steve was frequently observed in his own self-therapy. He was particularly interested in observing himself acting in the mirror -- playing out male roles

and risking physical activity. This appeared to be an important activity for him, so we planned the schedule so that he might be free to "do his thing" near the group in the same room when he wished. When he did this he was allowed free rein, although the adult present usually made occasional comments to let him know he was still part of the group such as "Steve likes to make faces in the mirror," or, "I guess you really feel like stamping your foot."

Steve's progress through the months seemed very slow at times, and it was a temptation to try more direct intervention. In the end we felt justified for our patience in that when he took part it was not because he had been forced or enticed by artificial rewards, but rather because he perceived a situation he could join. For this child, especially, the outreach and companionship with the group played a vital role in growth.

When Steve eventually evolved away from withdrawn, inert behavior we became more aware of the nature of his disability. In action he was a very awkward child. He had not established handedness, and he avoided activities using coordination. His art work was very primitive and unplanned. He ate voraciously without chewing adequately. It appears that underlying the emotional difficulties are disabilities that point to possible organic damage. The nature of his self-therapy indicated that he had very little feeling for himself -- or ego-strength -- and that he sought to feel himself, to trust himself, to risk masculinity. In spite of his progress, it is possible that his adjustment even at the end of school was marginal. Hopefully there was sufficient momentum to continue progress.

Steve's mother had many needs herself. When Steve first came to school his mother went to bed apparently with psychosomatic symptoms. She has had great difficulty setting limits for Steve; providing confident experiences for him; or even communicating honestly with him. Because of the nature of his problems, it was agreed that she would not visit school. During the year the teacher talked with her at least once each week. News that Steve was making a successful adjustment did seem to give her increased confidence in dealing with him. Three weeks before the end of school she requested a school visit, and arrangements were made for two visits, one for the mother alone and one for the parents together. While the changes in Steve did help the mother to relate to him somewhat more effectively, it was our impression that both parents still have considerable difficulty relating effectively with this child. We hope that the confidence he built in our setting can carry over to another school situation. According to parent report the school experience has made a significant difference in his willingness to move about in his own yard and neighborhood.

Case Three. Ronnie is a rather small, young-looking boy whose referral stemmed from his sister's difficulty adjusting to school. His mother had complained to the nurse that he seemed even more "wound-up" than his sister; was unable to focus on any activity for longer than a minute; and was constantly in trouble.

Our major goals for this child were:

1. Confidence building. Ronnie had many immature ways of behaving and in general seemed to feel inadequate about himself. The fact that he also sulked frequently and panicked occasionally, presented further evidence for rather deep-seated needs in this area.

2. Attention span. Ronnie had a very short attention span, much too short for survival in kindergarten next year.

His confidence was increased through many phases of the program in a group setting. He functioned happily in rather unstructured play and art activities, such as waterplay and finger painting, and was helped during the year to try more structured activities such as tinker toys and puzzles. From time to time one-to-one attention was either planned or provided to help him through a situation he perceived as overwhelming.

As his confidence increased he was able to attend longer to play activities. Group interaction also improved his play behavior. In addition, specific efforts were made to help him attend to adults -- particularly through books and stories. Initially, he was totally unable to listen to a story. Books were introduced to him through play-acting. After repeated use of this method, and by gradually decreasing the playtime and increasing reading time, Ronnie was eventually able to sit through a whole story attending to words and pictures.

Ronnie's mother tried to appear cooperative with the program, but her resistance was visible. She "forgot" meetings, evaded honest discussions, and appeared to gain little from interactions in the classroom. Part of this difficulty seemed to stem from chaotic home management, and related family problems. The mother also had to contend with elderly dependent grandparents; a mentally ill brother; a dependent stepsister and husband; and personal physical problems. Like Ronnie, she appeared to take life lightly, but avoided issues with a persistence that indicated otherwise. Perhaps her searching for answers to her personal feelings of inadequacy and need during the school term (feelings that she did express to us) were evidence that she was gaining from our treatment of Ronnie and our attention to her in some other areas. During this period, she took her

high school equivalence exams and passed them. She went to work and eventually seemed to be finding some success in the third job she undertook. These changes in her behavior seemed to have a negative effect on Ronnie initially. But it is likely that she could not offer him a secure relationship until she built some areas of confidence in herself. Hopefully, in the long run these steps will provide a more adequate family environment for Ronnie.

Case Four. Penny was a very small girl with mild cerebral palsy. She echoed speech and reversed pronouns. Her attention span was very short. She was referred because she seemed more capable than other children in a home training program for retarded children, and because it seemed possible that her behavior was the consequence of extreme over-protection by her mother.

Major goals for this child were:

1. Communication skills. We sought to decrease her echoing and to increase her ability to converse meaningfully.

2. Motor competence. When Penny came to us she could not go up and down stairs or feed herself with a spoon. Also, she was not toilet-trained. We planned to work on all of these skills.

3. Attention span. Penny flitted from one activity to another. We sought to keep her with an activity for increasing amounts of time.

4. Decreased manipulation of adults. She had several charming ways of preventing follow-up in an activity by manipulating the adults in the situations. She would recite nursery rhymes; show off with a laughing temper tantrum; and echo the adults' words. We wanted to ignore these manipulations and to encourage more complete participation in routine and play activities.

Communication skill and attention span were general goals at all times. Penny was engaged in conversations at her level and adults talking with her repeated questions and waited for answers when she echoed. At all times,

the adult present sought to keep Penny with an activity and to help her experience the variety of play it offered. For example, she was physically helped to pat and punch soft clay, to roll it and use a cutter, and in short, to experience the media rather than to touch it briefly and flit away.

Motor activities, such as climbing stairs, took more specific planning. Because of the many stairs in our building, much time was spent in helping Penny learn to walk up and down stairs. We began this activity using low play stairs found in nursery school equipment. An important part of this therapy was the risk we took in letting her walk down the stairs alone. Competence with a spoon was dealt with at meal times. In the early weeks her food was served in a bowl to make spoon use easier. Attempts were made to include sticky foods, such as mashed potatoes, puddings and thick soups in the school diet. Both at school and at home she increased in her self-help skills at mealtime.

Decreased manipulation of adults required many periods of patient waiting -- waiting until Penny tried all her manipulative devices, but still insisting that she do simple tasks for herself. While her manipulation became less effective for her and decreased to some extent, it became evident that she used these ways, not so much to avoid effort, but as a means to avoid what she actually could not do. No matter how long we waited or how hard she tried, in the end it took adult help for some tasks such as putting on boots or stringing beads.

Thus for Penny (as for some of the others) we discovered, by working with her overtime, the extent of her disability and the nature of her limitations. In addition, a formal intellectual diagnosis was made by our staff psychologist. We found in general that her intellectual ability

was more limited than we had at first hoped. While she had definitely been overprotected, there were limits to what she could learn, not because of emotional problems, but simply because of personal limitations. During the final weeks of school, we had further communications with Beekman Center, the facility for trainable retarded from which Penny was referred, and indicated to them that we predicted she would return to them in time.

Penny's mother was able to make changes under direct supervision. She had been bluntly accused of overprotection by other professionals before she came to us and was receptive to our suggestions within limits. At our insistence she immediately stopped carrying Penny up and down stairs. At home she initiated a plan of behavior modification for toilet training and followed it carefully even though it proved to be a long, slow process. She increased her encouragement of Penny's personal independence through experiences outside the home such as weekly lunch at the drug store. It was also evident that Penny's mother had focused her whole life on this late-born atypical child in a demanding and over-protective manner -- a manner natural to her personality, but a manner that could not be changed drastically through our program. However, by the end of the term it appeared likely that the combination of the changes she did make and Penny's increased opportunity for experiences outside of the home can probably allow Penny to develop within the limits of her physiological potential. At least to some extent Penny's mother's need to protect her can be used positively with this child who will always need protection and special care.

Case Five. Vickie is a sturdy girl who is the only child of a young Negro mother. The mother is a person who copes well within the limitations of a welfare aid budget. Vickie was a healthy but very placid infant who was first noted to be silent and unresponsive at the age of eleven months. Family members wondered whether she was deaf. She became very difficult to manage between two and two-and-one-half years of age, and was taken to the speech clinic at the age of three. The clinic reports that initially she was extremely withdrawn but later became more outgoing. Still, they felt that she did not yet relate normally. She was also subject to unexplainable bouts of uncontrollable weeping. At the time of referral she had a vocabulary of four words.

Major goals for this child were:

1. Verbal skills. Since acquisition of functional speech by the age of five or six is extremely important for future development, the development of useful verbal skills in the context of play and social activities was a primary goal.

2. Social skills. Vickie did not seem to know how to play or to relate to other children and adults. We wanted her to learn the joys of play and of social interaction with both her peers and the adults in her life. While these goals might be present for any child in a pre-school setting, Vickie appeared to be a child who would need specific planned experiences to further her development in these areas.

Vickie's needs were so great, especially in the early weeks, that one to one attention was required during therapeutic periods to encourage her into activities. We soon found that she responded when she could participate in activities that were highly stimulating, and that speech came out spontaneously and in imitation when she was barraged with words and excitement. Therefore, most of the activities planned for Vickie included activities which aroused her interest at a high level. At the

same time the adult in the situation then stimulated her verbally by talking loudly about the activity in simple relevant phrases. For example, while sliding on the slide she learned to bellow "sit down" and "do it again" in the midst of joyous group activity. While tumbling on a mattress she called out to another child "come on" and "get off." These were some of her first spontaneous words. On one of the last days of school she was observed up to her elbows in yellow finger paint enthusiastically yelling, "Lellow paint, lellow paint." Although Vickie continued to need close supervision, particularly to learn a new activity, she was increasingly able to benefit from a group activity with only sporadic individual adult attention. A few times, in a stimulating setting, she was able to interact with one or more children without any direct adult intervention. While she still has temper tantrums, it is generally quite clear what she wants and she increasingly makes her needs known more constructively, although not verbally as yet.

Although her history is not fully known, a combination of bits of known history and classroom behavior indicates that this child may be diagnosed as a case of early infantile autism. Her treatment and her response has been similar to that described by DesLauriers (1969).

Vickie's mother has shown great determination to help her child. In spite of her own shyness and depression, she had already put forth unusual energies to get Vickie to the Speech Clinic through two cold, snowy winters. When we started she was very discouraged by the lack of speech progress, as well as by Vickie's tantrum behavior. As Vickie became more verbal her mother became more positive and outgoing (this was even visible in changes in her dress) and thus better able to help her child in an enthusiastic manner.

In addition, Vickie's tantrums have become more manageable, relieving pressure on her. How this was accomplished is not clear. Possibly the child understands and expresses herself more and is less frustrated; perhaps the mother has been able to be more firm and consistent because of her increased confidence in herself. She has responded well to our instructions about playing with Vickie, and she works well with the teacher when learning new ways to interact with her daughter. Vickie will continue in the therapeutic unit since she is not yet eligible for kindergarten, and it appears that both mother and child can continue to benefit from this program.

Case Six. Gail was brought into the school setting in late March -- long after the other children were adjusted to the school routine. We had not originally anticipated having a sixth child, but her attendance was made possible and encouraged for several reasons. First, she urgently needed a group experience with young children as a part of her development. Second, she would attend only part-time and she came with a helper who was to be responsible for her safety as well as for helping her participate in activities. Finally, Gail was the most atypical child in the group -- probably as atypical a child as one might ever find for a group -- and we wanted to test the limits of our program in dealing with such a child. When Gail came to school, she had no normal peer experiences because of her own withdrawn autistic behavior. She was functioning with only minimal skills -- she spoke only two or three words, none functional; she was not able to feed herself nor was she toilet trained. She resembled Vickie in some respects, but her behavior was a great deal more primitive.

Major goals for this child were:

1. Interpersonal interaction. We wanted to provide stimulating experiences in which Gail would interact with adults and peers.

2. Speech. As with Vickie, the development of speech was a primary goal (Gail was five when she entered our program). We believed it was likely that we might get speech as we did from Vickie in exciting stimulating settings.

At first Gail attended only for the periods of outdoor play, lunch, freeplay, and rhythms on Monday and Thursday. On both days some effort was made to reach her through rhythm exercises and outdoor activity, which she enjoyed. She also gradually joined the group for meals and seemed to improve in her interest in food and ability to feed herself. On Thursday, the therapy period was planned so as to include her in a particularly relevant activity. For example, she might be placed with another girl for waterplay or active playroom fun. Sometimes the teacher worked with her alone. In any activity Gail had to be held and led through the motions, although occasionally she would take over briefly for herself. For example, after several minutes of finger painting with her hands held to the surface and moved by an adult, she might continue some herself, or likewise after jumping up and down with adult help in a group she might continue to jump alone.

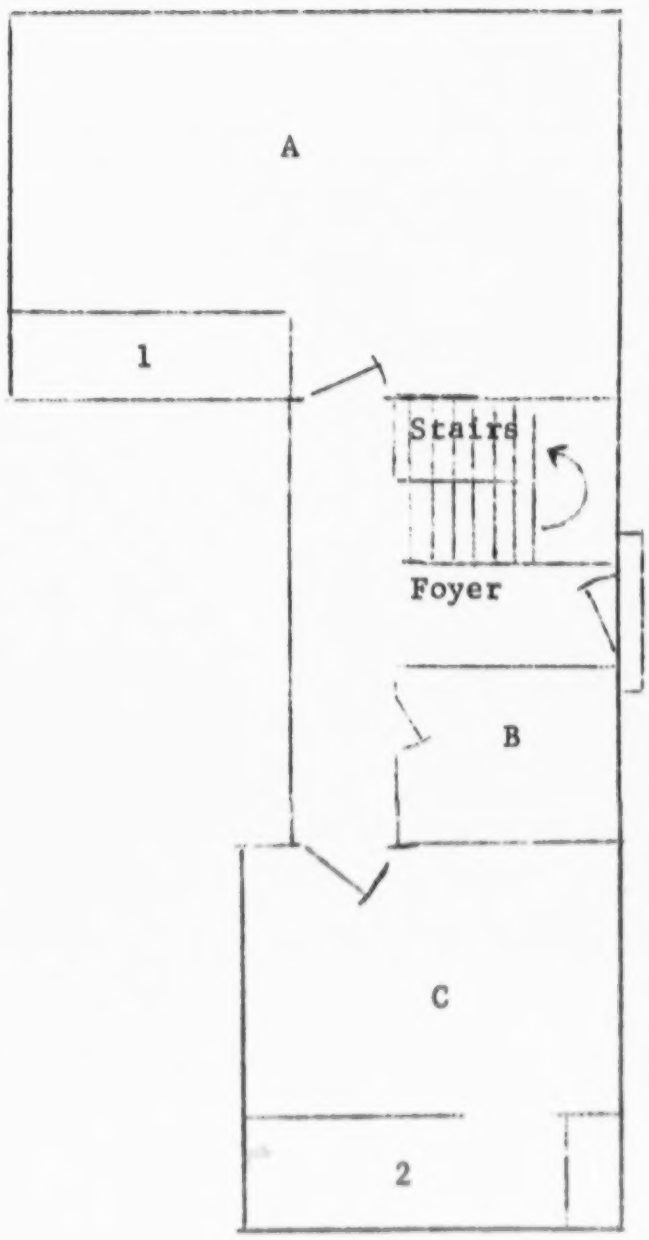
As with Vickie, adults used words relevant to the activity loudly and with great excitement in the hope of encouraging some imitation. These efforts were rewarded. Although her response was limited, after the first few weeks of school, she imitated some word or phrase, such as "Hello", "Goodbye", and "Go back" almost every day. These verbalizations at school were the first clear evidence in any setting that there might be at least some potential for language development in this child.

After several weeks on this limited schedule, the staff decided to add another full day to her participation, but without the one-to-one helper. By this time it seemed that Gail could be managed within the setting as long as there were three adults for the six children (rather than the minimum staff of two).

While the inclusion of such a child might not be advised for all settings, we were satisfied at all three levels of our reasoning for including her. The experience clearly was a benefit for her, even in the few weeks she attended. With the part-time schedule plus some additional help at first, it was possible to manage her in the group.

Setting

The therapeutic class met in several rooms of an unused preschool unit in the Institute of Family and Child Research. (See illustration on following page). The area consisted of one large carpeted playroom (A) with its observation booth (1), a medium sized room (C) with an adjoining bathroom (2), and a small tiled room (B), originally intended as the testing area. The illustration shows how the rooms are separated by a long hall and foyer which serve as the entrance for the 4-year-old preschool unit upstairs. The lunch was served in a carpeted basement room (below C) which also served as the video taping lab for the Institute's research programs. The disjointed arrangement of the facility caused a great deal of adjustment before we felt we were using it all effectively. Because the rooms were so definitely separated from each other and many other people traveled in and out of the foyer to go upstairs, we felt we could not allow the children free access to all rooms at all times.



We initially were uncertain whether or not some children might run away, and also we had some very definite therapeutic goals which necessitated close supervision most of the time. Therefore we planned an activity to take place in one particular room and with certain children and adults. When the activity was finished, the adult and children might then go to another area as planned, but we did not allow the children to wander freely throughout the facility, as might be done in a normal preschool setting.

As we began to plan room usage, the tiled floor and its proximity to the bathroom suggested that room C be designated as the "messy play" area. The size of room B suggested that it become the individual therapy room. Room A was equipped much like a normal preschool classroom -- including piano, housekeeping/doll corner, blocks and accessory equipment for large muscle play, and cupboards with puzzles, trucks and cars, and a variety of manipulative toys. This room was used for very active and noisy play because of its wall to wall carpeting. Moreover, it also was the only area with an observation booth and thus was

the setting for any demonstration teaching we did for mothers, or visiting professionals and consultants. The room was comfortable and well lighted and we generally introduced children and parents to this part of the facility first.

As our teaching progressed, we adopted a more definite approach with each room. Room B was not used as frequently for testing as we originally thought necessary, and thus could be incorporated into the teaching plans. Activities such as the work bench, water play, cooking projects (preparation), or sand play which had inherent fascination for the children could be arranged ahead of time in Room B. Another use we had for the room was individualized therapy with one or two children. For example, we set up the small doll house and rubber figures and then worked with Vickie alone in that setting. Away from the other children, we could vigorously reward her attempts at speech and do some definite speech modeling. Some times such activity was too distracting for the other children to be near.

A special advantage of Room B was the fact that it could be easily cleared of all "things" and the teacher/therapist could then focus a child's attention on simple human interaction. For Vickie and Gail, this was a vital part of the therapy process. A final use of this small room was to force, through physical crowding, some psychological togetherness in our group of children. Initially at music/dance time, and later with some language experiences, we placed all six children and three adults together in this room. With no extra materials present, the human interaction was brought into main focus. We used songs and poems which could be personalized with a child's name and we concentrated the group's attention on each individual in the circle. We also attempted some "togetherness"

ideas, notably through simple movements. When we did more dancing and group games, we moved into Room A. Until the end of school we still used Room B for the period following lunch as a "womb-like" atmosphere when the group seemed particularly tired.

Room A functioned as a stimulating backdrop where materials were perhaps a bit more important than in the other two rooms. From the beginning, we allowed the children more freedom in Room A. When one particular activity was finished, we allowed the children to choose something else which interested them from a selection of items we provided in that room. For example, we might work with the three boys on a lotto game for some therapeutic goal and then they might choose to build something from the blocks. The teacher would support and participate with them in that play also. Not only were the boys more active and in need of space to move about, but they also possessed more advanced play skills and more self-direction than the girls. Because therapy with the girls was perhaps more intensive and individualized, we more often needed to place the girls in a less distracting setting than Room A.

Throughout the school period, Room C served as the stage for art work and messy manipulative activities. Unless we needed to stage something in Room A for the particular benefit of a mother observing that day, we generally did painting, clay and playdough work, water play, collage work, etc. in Room C. While this room was large enough to do some vigorous physical exercises with Penny, Gail, and Vickie, it also suffered for that purpose because it was on everyone's path to the bathroom. Interruptions were frequent when working in Room C; and for two children particularly, it was difficult to draw them back into an activity again. While we might

work with one child in Room A for the entire morning, we rarely did this with Room C and never in Room B.

Room C contained an easel, a chest for colored paper, and a variety of tables. A child could thus always help himself to paper and crayons, chalk, or paint if he did not wish to join some main activity which we had set up. For Steve, Room C was a frustration which he gradually learned to deal with. It was small enough so that he could observe an art activity from a small distance without getting physically involved. However, it was not so large or well equipped to offer him unlimited opportunities for isolated, self initiated activity, as in Room A. Steve first began to participate in Room C. He first helped with the clean up process and gradually moved into active play with the other boys.

The basement lunch room was heavily used and we were always in danger of overstaying our welcome there. This made it difficult for the children to participate fully in the preparation of foods, but its location did have two advantages. The fact that it was quite removed from the other classrooms offered a psychological "break" for all of us, and we could form different groups or relate in different ways than we had been doing in the morning period upstairs. For Penny especially, the necessity of climbing up and down stairs at least once a day was consistent with our goals for her physical therapy.

There was a basement "rainy day room" in the building which was equipped with tricycles, a slide, tumbling mattresses, and a punching bag. We made use of it for physical activity, especially for Penny and Vickie. This room provided the possibility for very active gross motor activities and was used therapeutically when a child or children needed to vent aggression or tension.

We had the use of a large play yard at the side of the school and we played vigorously almost every day. The children loved to swing, slide, and climb jungle gyms and trees. The tricycles were used on the sidewalk inside the yard. There was also a large sand box and a play house with a ladder to the roof. The huge yard which offered running room and freedom was a delightful contrast to the small rooms inside. The teachers participated actively in outdoor exercises with the children. These activities increased feelings of confidence and freedom for both children and teachers.

The fact that the Institute is located on the university campus meant that the children saw many people walking by the yard, especially since we played outside at noon. At first the children seemed oblivious or fearful of the passersby, but toward the end of the school year we had some delightful conversations with people who were interested and stopped to talk. We felt as if these small, positive exchanges were an added benefit for the children as they grew in confidence and social skills.

Transportation

At the outset of the program, since we had a van and a regular driver, it seemed that transportation would not be an area of our administrative concern and decision making. We later found that transportation problems occupied our attention often. Realistically, any routine for picking up young children will not go smoothly every day -- humans are just not that regular! When our driver was delayed in picking up the early morning group, she was late in beginning our run. This meant that not infrequently our children were ready and waiting for some time before the bus arrived. For all the mothers, this was inconvenient, and for several, it was upsetting.

Because the driver's afternoon schedule still had to be met, our program would be shortened to compensate for the delay.

The children's homes were scattered widely in the West Lansing area and the bus route took at least one and a quarter hours to complete. This meant that one or two children might be riding on the bus as long as forty-five minutes. From the beginning, the teacher, aide, or student volunteer rode with the driver and worked with the children. Books, puzzles, and puppets were used to involve them and we always sang songs and shared poems. Eventually we decided to carry crackers on the bus and let the children eat part of their snack before they arrived at school. We found two sit-down meal times at school unnecessary and some of the children had eaten breakfast early enough so that they were a bit hungry by the time the bus arrived around ten A.M. We viewed this transportation time as a relaxed opportunity for the teacher and the children to converse about things that interested them. We made extensive use of observation and discussion of the world around us as we traveled to and from school.

Time spent on the bus also was used as an informal assessment time. When a child got on the bus in the morning, the teacher took five or ten minutes to talk directly with him. Not only were these little conversations friendly and enjoyable, but they also helped us learn how the child was feeling. Special support and understanding in these initial moments could improve everyone's day. As the bus stopped at each home, the teacher always got out and talked briefly with a parent or babysitter. Parents related significant events in the family and child's life. We might learn of an exciting trip the child had taken and respond at school with some curriculum materials that reinforced his learning and enjoyment.

For example, on one occasion Marvin's family had gone to the bike races, and Marvin responded with great delight to the story of Curious George Rides a Bike. Especially for this group of children, we felt it was important to learn if their regular routine of sleep or meals or health had been upset in any way. We could, therefore, adjust our daily plans with more sensitive prediction of a child's coping ability. In turn, we tried to mention to the parents significant events of the child's previous day at school. Especially for one family, which had a history of poor communication with the public school regarding older siblings, we felt this regular exchange of information was very important.

Some physical aspects of the vehicle interfered with the teacher/child relationship on the bus. It was a large vehicle for a woman to drive and frequently the driver would ask for the aide's assistance in helping her through lanes of busy traffic. Since these were usually emergency-type situations, the aide would have to interrupt her educational efforts with the children to assist the driver. In addition, the seats were perpendicular to the length of the bus and the aide was of necessity separated from some children. Especially in this group of atypical children where we tried to encourage communication and relatedness, it was unfortunate to be seated in "pews". If the vehicle had seats along the sides, the aide could see everyone and encourage more group interaction.

At the beginning of the program, we naively commented about "when things get settled down." We finally learned that work with disturbed children whose families are often disorganized in some manner, does not settle down into a neat routine. This often affected the transportation arrangements. There were changes in family situations which involved

different babysitters and sometimes different houses. Parents would leave for errands and no one would be there to meet the bus. We sometimes were requested to return children to a different house, which would delay an already long ride for these children and frustrate the driver. In retrospect, we concluded that from the beginning both parents and school should have planned and communicated more in advance about changes in routine, and that some policy about reasonable changes should have been established. In addition, an emergency or alternative "drop off" procedure should be developed for each child. Realistically, such incidents are not infrequent in Head Start classes, and with atypical children especially, the routine should be as secure as possible. Home and school should each share some responsibility in preventing frequent changes that often upset children.

Another complication relates to children who are receiving other programmatic services. Vickie, for example, was seen by the speech clinic three days a week before she arrived at school. This is a typical situation for multiple handicapped children, and it is necessary that some kind of policy for the transportation of such children from one agency to another be established. In some cases, a child might be retained in the program only if such special transportation arrangements can be made. Certainly, a realistic understanding of how many exceptions can be made and not interfere with effective operation of the class is important.

In total, the transportation arrangements were "complicated" because of the stated physical drawbacks of the van, the driver's complicated schedule, and the changes in family routines. However, the transportation time can be an opportunity for education and friendship, and it is an

important step for the preschooler meeting the wider world beyond his home.

Orientation Schedule

We viewed the orientation to school for our children as being of crucial importance. Therefore, our plans were individualized for each child. With individual variations, we tried to see each child alone or at school for a one hour initial visit. Then we saw two children together at school for about an hour and a half and finally, the whole group was together for a two hour school day. The entire orientation to a full schedule took four weeks. The gradual introduction to school was very important for both children and families as well as staff. As soon as a schedule of orientation was made up based on our knowledge of the children, copies were given to all staff members and families. The teacher planned the mode of transportation for each child's visit (parent's or teacher's car or bus) and included this information on the outline for parents. The bus driver met all the children during one of their first visits to school and the teacher talked with her about what to expect from the children and how she could help each one.

Because Steve and Penny seemed to be appropriate referrals from other professionals, the teacher met each child with his mother in the school setting for the initial contact. Since Penny was very verbal and curious with no sign of great apprehension in new surroundings, we saw her once more alone in the school and then she came for two hours with Ronnie. One of our goals in this initial period was to record curriculum materials that each child seemed to enjoy. Penny seemed very interested in the doll

corner and the piano; we also noted her echoing pattern and tried different techniques to deal with it.

Steve came to school with his mother to meet the teacher for our first contact. Though some attempt was made to show him the school rooms, he clung to his mother and/or sobbed with his face in his arm. Seeing the great tension that both he and his mother felt, the teacher then made a home visit to Steve's house at a time when his father was also home. Steve then had three more visits to school with his mother before he joined any of the other children. Part of the reason for the three visits was to introduce him to the school, the bus, and the driver in a gradual way. His mother brought him on the first visit and she stayed in the room with him for the whole hour. The second time, his mother came with him on the bus, accompanied by the teacher and they went home on the bus with the aide accompanying them also. For the third visit, he again came on the bus with his mother and teacher, riding home with his mother and the aide. Since it was the aide who would generally ride with the children, we wanted to get him used to this arrangement.

During the second and third visits, Steve's mother left him soon after they arrived. While the teacher stayed with Steve, his mother talked with the psychologist in a basement room. While these visits to school with only his mother present might have hindered Steve's adjustment to the classroom, they were seen as important orientation for the mother. The teacher called her in the evening after each visit to tell her what had happened in the classroom while she was gone. Steve seemed to fall into a pattern of behavior after the first visit. He would howl loudly in rage when his mother left and continue for about fifteen minutes, clinging

to the door. When he gradually quieted down the teacher would read to him. We had learned from his parents that he really loved books and sand, so these two activities were always set up for each of his visits. Steve would listen to several books, pick up one to clutch in his arms for the return trip home, and wait by the door for his mother. The early behavior seemed to be a precursor of other "patterns" in school which he found difficult to relinquish. Steve's mother showed great anxiety paired with determination in this early period. We felt it was a healthy sign when, after the three visits, she declared that Steve would be better if she were not there and other children were! The first time Steve came to school with other children, the teacher rode along on the bus. After three trips, the aide then rode on both the morning and afternoon trips. With each change, Steve would show panic and sob tensely, but if we talked gently to him now and then and permitted him to cry out his tension, he usually would regain composure within about ten minutes.

We were not initially certain whether Vickie, Ronnie and Marvin were appropriate referrals for our program because of the reported severity of their problems, and we needed some indication of parental willingness to cooperate. Therefore, these children were seen initially in their homes and the program was described as a possible opportunity for their child. The psychologist visited in Ronnie's home twice before he was accepted into the program. The family was in constant chaos and it took time to bring Ronnie into focus as a unique person against the complicated environment. He visited school with his mother and sister once, and was then paired with Penny for a visit. We saw both Penny and Ronnie as having a gregarious friendliness which helped them accept each other and made them reassuring companions for Steve.

Marvin's mother showed great interest and cooperativeness and Marvin seemed like a child who would benefit from our class, as well as being a stimulating companion for Ronnie and Steve. He and his mother came to school for one brief visit when the other children were there and the next week he entered into the full schedule. Both the teacher and the psychologist had visited in his home and did not feel he would be overly apprehensive about school entrance. In fact, his behavior at home suggested to the staff and his mother that he needed to be in such a program as soon as possible.

The teacher visited Vickie in her home once before she and her mother came to school. We had already received helpful information from a non-professional worker who had extensive contact with the family through the Welfare Department's Family to Family Plan. Vickie did not seem at all shy of new people and places. Conversely, she appeared somewhat oblivious to them at times, and was seen from the beginning as a child who needed experience with peers. After the first visit, Vickie came two times the following week just after her speech therapy session. As soon as the transportation problems were worked out, she participated every day.

During these initial weeks, the teachers stayed very close to the children giving abundant support and explanations. We quickly realized that we needed to let Steve make his own decisions on entrance into play; but we immediately saw that Marvin and Ronnie needed some definite guidance and setting of limits. We found the girls more enigmatic and tried a number of different approaches to helping them become involved with materials. We found that Vickie could easily communicate refusals and

withdrawing, but not much else. Penny echoed our speech and we would wait and repeat a statement or question until she responded more appropriately.

Mothers were contacted frequently by either the teacher or the psychologist and the aide took information and reassurances home with her each day. We feel that the rapport developed with the families was encouraged by the manner in which we approached the orientation process. We did want to reassure the families that each child would eventually be participating fully in the regular routine and that special exceptions would not be desirable, such as one mother transporting her own child to school. However, we recognized that each child should be seen and planned for as an individual. The gradual orientation gave mothers, children and staff all time to accomodate to these new experiences.

Meal Times

From the start of the planning for the therapeutic preschool, Dr. Melcer had wanted to include a meal as an important part of the therapy process. Because of the transportation schedule, the children were served a snack when they arrived at 10:30 and received lunch at 12:30. While the meal program was frustrating because of limited equipment, space, and time available for planning and preparation, the rest of the staff grew to affirm Dr. Melcer's belief that valuable therapy is accomplished at meal time.

For each of our children, meal times in their home were marked by some degree of psychological stress, although it was some time before we realized that they were all thus affected. We feel that meal time as a therapeutic process needs further investigation.

Since the children were usually split into two or three groups for the morning therapy periods, we felt it was important for all of us to eat at one table. A formica-topped rectangular table was purchased for this purpose. Initially our aide served each person's plate before we entered the dining area, but later we changed to a "family style" of serving. We believed that it was important to provide each child with the opportunity for cooperation and decision-making as he served himself. As each child looked at the food offered, then decided if and how much he wished to take, we felt he was exercising his selfhood in a significant way. Besides the opportunities for choice that this way of serving provided, we also could practice language patterns by encouraging children to express their needs to each other. At first the children usually asked an adult for assistance, but gradually they learned how to ask each other. When they became frustrated by another child's lack of response, we were able to point out how they might improve their communication skills. Ronnie was able to learn that just yelling "Give me the sandwiches!" was not as effective as first yelling another child's name and gaining his attention before asking for some food.

Meal time also provided an opportunity for the children to increase their vocabulary as we stressed using the names of the various foods, utensils, dishes, and cooking methods we used. When mothers were able to watch the meal time on closed circuit television, we could effectively point out how we encouraged language in this way. This kind of demonstration teaching seemed to illustrate well our belief that parents need help in recognizing the educational possibilities which are inherent in their family routine.

A third value of the "family style" of serving, particularly for Penny and Steve, was simple practice in muscle coordination as they passed dishes from one person to another. Related to this value was an opportunity for a child to handle progressively more stimuli and yet maintain their original task of eating. For Penny, Vickie, and Gail, and to a limited extent for the boys, meal time was a complex process, part of which was "tuned out". They would begin eating their own food and could not be distracted from that activity long enough to respond to a question or pass a dish to someone. It appeared that they were focused at one sensory level, much as the toddler must focus in learning to walk, and their other senses could only be aroused with a high level of stimuli. One good example of the differences in the children's ability to attend to several tasks at once was the fact that Marvin could easily converse with the adults while he was eating, while a child like Penny either ate or talked, but could not perform both skills at the same time. We were, therefore, selective in directing questions and conversations, and tried to help each child make progress toward handling more stimuli.

Marvin arrived at school for the first day when we were making split pea soup. He liked this activity and was very skilled in cutting up the vegetables and meat. Later, we realized what a therapeutic exercise that had been for him. A great deal of family conflict preceding his parent's separation had been centered around meal times. Marvin had learned to copy many of his father's abusive comments about his mother's cooking which, of course, alarmed her and made meals a constant problem. Marvin's mother was extremely overweight which might suggest that meal times may continue to be psychologically significant for this family. Actually, Marvin did

not present a great management problem at meal time. He did, however, test his conflicting feelings by "shock comments" like "This is yucky food!" or "You're a bad cook!" When we simply reflected his feelings with such responses as, "sometimes you don't like the food we have," or "everybody doesn't always like to eat," he would relax. We did encourage the children to try all the food offered, but we used no hard and fast rules. If someone obviously wanted to eat only dessert (Penny in particular) we might say that they needed to eat a certain amount of food they had taken, but we tried to keep from precipitating any real conflicts about eating. Marvin's mother reported that he liked to help her cook and one of our most successful parent/child interactions at school was when Marvin and Ronnie made pizza for their mothers.

Marvin was the child who was most distressed that Steve was not eating at school. His mother reported that they discussed Steve every night and we all tried to assure him that "Steve will eat when he wants to." Marvin's visit to Steve's house during spring vacation seemed to be particularly successful, because it revealed to Marvin that while Steve did not talk or eat at school he really could and did! Marvin continued to eat well at school and occasionally fabricated "food stories" to his mother. For example, he said, "I didn't have any dessert today, because I didn't eat my carrots." Marvin told us emphatically that he did not like raw carrots and perhaps his good adjustment to the eating situation was helped by our acceptance of this. Since carrots were cheap and easy to prepare, we frequently had them at school, but we made it perfectly clear that Marvin was free to decide whether he wanted some or not.

When Ronnie entered school, he seemed physically less mature than the other two boys. His bladder control was not good, and he made at least three frantic dashes to the bathroom each day. In addition, he was smaller than the other two boys. His mother had reported that he was a "picky" eater. She was, therefore, appalled to see him "wolf" down his food at school on one of her visits. The differences in his eating style may reflect the fact that his mother tended to be very critical of him and frequently directed him with negative comments. More than any other child, he seemed very fearful that there would not be enough food; and, therefore, made very little progress in judging how much he could realistically eat. We frequently asked him to stop and consider whether "you really can eat all of that." In actuality, Ronnie may have viewed even these questions as a form of criticism like his mother's. He always enjoyed the social setting of the lunch time and could be counted on to furnish songs and stories to entertain us all.

Steve was underweight when he entered school, and it is possible that meal times in his family had been marked by great anxiety. His mother had had two ulcer operations involving lengthy hospitalization, and although she claimed that family meals proceeded normally, she did have some dietary restrictions. It is likely that Steve knew that food and stomachs somehow related to her health problems. In spite of our many attempts to encourage his participation, he refused to eat until the fourth month of school.

The teacher communicated frequently with Steve's mother about his behavior during meal times. From the beginning, we did place some restrictions on his behavior. While he would have preferred to play by

himself in another room while we ate lunch, we insisted that he remain in the same room with us. Then he attempted to bring a book or some toy into the room to entertain himself while we ate. After the first few days we made it clear that such props could not be used. Yet, beyond these limits, we largely ignored him during the meal except to positively reinforce him when he ventured close to the group. He soon began assisting eagerly in the process of clearing the table and cleaning the room. One of the reasons we changed to a family serving style was because we felt Steve might be overwhelmed at a filled plate and fear that he might be expected to eat everything.

From his mother, we learned what foods Steve really liked and tried to include them in the menu. Once Steve's mother revealed that when he returned home from school hungry at 2:00 P.M., she fed him then. After a discussion, she agreed not to do this, and supported the school's attempts to help him eat with the other children. Perhaps another step on the slow road to eating occurred when Marvin visited at Steve's home during vacation and the two boys ate together.

Another part of the process of getting Steve to eat with the group was to involve him frequently in cooking projects for lunch. We made cupcakes and frosting (knowing that Steve really liked sweets) on Tuesday of one week and he licked out the pans with Marvin and Ronnie. Picking up these clues that he might soon eat a whole meal, the assistant teacher took Steve, Marvin, and Ronnie on several "picnics," one day in the basement play room, and the next time in Room B upstairs. Each boy carried his own sack and Steve's wish to eat was obvious. He did not eat, however. The first day he actually ate was when we sat Steve and Marvin at their own table in the

lunch room, hidden from the rest of us by a cardboard screen. When Marvin yelled, "Hey, you guys, Steve is eatin'!", we had a great deal of trouble replying calmly "Oh, that's nice."

We continued the hidden table arrangement for a couple days, sometimes letting all three boys eat there. However, it soon became apparent that Steve was very pleased with his new behavior and wanted to be noticed and rewarded more directly. He grinned and showed us his empty glass and plate and came to the big table several times for more food. Next we set his plate at the big table, but when faced with that sudden shift, he refused to eat and retreated to standing against the wall again. The next day we again sat Marvin and Steve at the small table, but with the screen removed. After two more days, we once more placed him at the big table and he joined in. From then on, he eagerly consumed snacks and lunches. His totally happy appearance at meal times when he eventually joined in seemed to justify our patience and lack of pressure throughout the tedious process of involving Steve in eating food with a group away from home.

Penny only weighed 26 pounds when she entered our school. She was very poor at manipulating her eating utensils and her mother admitted that she had fed her an unusually long time. Penny still turned the spoon upside down just before it reached her mouth and even though by the end of June we felt she was more skilled, progress was very slow. Penny had definite food preferences of finger foods and sweets. She used all of her charming dependency routines to avoid practice with her utensils. The fact that she understood this goal was obvious from the way she looked directly at us whenever she began eating with her hands. We felt that her

mother's extreme protectiveness was manifested by the fact that she was the only mother who sent cookies to school with Penny several times. On such occasions, Penny exhibited a single-minded determination to eat only cookies at lunch. Furthermore, she would mention the cookies several times during the morning classroom sessions.

We also felt that Penny's wispy long hair interfered with her becoming a more skilled eater, as well as with other manipulative skills. The hair above her forehead was continually falling into her eyes and in her attempts to brush it away she frequently got food (as well as paint, paste, etc.) into her hair and eyes which resulted in even greater annoyance. We did persuade her mother to make a ponytail but even though the psychologist mentioned these further problems to Penny's mother several times and suggested that she be given a haircut, the mother never responded.

When we saw Penny's total ineptness at meal times, we made certain she was always seated next to an adult and was given small servings with only a spoon to manipulate. We frequently had soup, chili, or stew which she could drink from a cup together with many finger foods -- raw vegetables, fruit, cheese cubes, sandwiches, hot dogs, hard boiled eggs, open faced sandwiches, etc. We served Penny's food in a deep dish, rather than on a plate as for the other children, so that she could have an edge to push against. We cut meat into bite sized pieces and served "sticky foods" such as mashed potatoes, thick lentil soup, thick chili, stew, puddings, cole slaw, creamed tuna, and heavy salads. Penny was a child for whom the goals often became conflicting and we needed to make value judgments about what was most important. She was very thin and susceptible

to illness, so it was tempting to let her eat food by any method she devised. However, we felt that she needed to develop independent eating skills.

Meal time was difficult for Penny. Because of the great variety of stimuli present, she became easily confused and could accept only one simple direction at a time. When we began the family style of serving, it was distracting for Penny to be interrupted by dishes being passed, but it also gave her much needed manipulative practice. One good illustration of her functional level occurred when the children cleared their own dishes and then helped themselves to dessert from a side table. Penny would take her dish out to the kitchen, then return to the table often forgetting where her place was. She would see another child eating dessert and awkwardly get up and move to the side table. Penny would fill the serving spoon with food and <u>then</u> look for her dish. If the serving bowl and small individual dishes were some distance apart, she would not move them any closer. Her dish filled, she would go back to the main table, again forgetting where her place was. If she wanted more dessert, she would get up and go to the side table, but did not realize that she needed to take her dish with her. At times when we simply waited to see if she could solve this problem, she would just take any available new dish or carry a dripping spoonful of food back and forth between the two tables. If we reminded her that she needed a dish, she would seize any one that was near, and again would forget where her place was. All this description about Penny has been included to illustrate that if Penny is to learn to help herself, the adults around her must lay careful ground work. A great deal of time and patience will be required

and routine tasks must have simple and invariant patterns.

Vickie's eating problems were similar to Penny's in that she was not skilled in using utensils and a variety of stimuli tended to confuse her. However, she weighed 20 pounds more than Penny, and while she had definite likes and dislikes about food, she usually enjoyed eating. In fact, at this point we felt that she could easily become overweight and we tried to limit her intake of high calorie foods. If Vickie really liked a food, she would grab it off other children's plates or go about the table looking for more. If we were quick enough, we would rescue the other child's food and say, "no, Vickie, that's so-and-so's food." She would then usually cry, kick and scream at this interference. If there was more food on the serving plate, we offered it to her; if not, we explained in simple terms. By largely ignoring her tantrums at meal times, they virtually were extinguished by the last month of school.

Since Vickie likes to eat, we felt we had an excellent setting for teaching functional language. Initially when she indicated a desire for a second helping of some food, we would hold that food and say its name clearly over and over while we tried to get her to imitate us. We had very little success with this method. She seemed to have a great need for food, and a low frustration point which enabled her to retreat into twisting her hair and ignoring us. We then tried to teach her to say "more" by doing elaborate demonstrations of the results of using this word in the meal setting. Each adult would ask for "more," and receive more food from another adult. Eventually the other children got into the act also, loudly declaring, "I want some more!" We accompanied Vickie's actions with the appropriate use of this word, such as,

"You're taking more fruit, Vickie. You're having some more." Eventually Vickie was heard to use this word several times at lunch but in the final analysis both we and her mother felt that meal time seemed to evoke very little functional language.

Our feelings about this aspect of Vickie's behavior were largely speculative. We felt that food alone had been personally satisfying for quite some time and she concentrated on its sensual satisfactions. Eating was a private pleasure and a necessity, but unfortunately it seemed to have a limited amount of social meaning. We did see her make real progress in her ability to respond to another person's request to pass the food when asked.

When Gail first started attending school part time, we anticipated that lunch would be a difficult time and made appropriate plans. The extra adult who accompanied her to school sat with her at a small separate table and helped feed her. Gail ate as if in a trance. She often jumped out of her chair and wandered around the room, and usually was taken elsewhere to play until the other children were finished. One day when an extra place had mistakenly been set at the big table, Gail went to it immediately and looked at all the children seated around the table. For her, this was an exciting and positive response. Soon after, we set her place at the big table with the other children. When she eventually attended school two days per week, she was accompanied by a therapist who sat next to her at the table and helped her eat. Gail showed good eye contact with the other children and seemed interested in their actions. She remained at the table longer and seemed less interested in getting up to wander about. In total, the staff felt that Gail showed

more awareness of others and displayed more self-help skills when an extra person was not there just to help her. She seemed to respond more normally when she was treated more normally and a private helper seemed to provoke more withdrawing behavior in her. We included her in our normal routines of passing food, clearing plates, and serving dessert. Even though Gail had to be moved through these tasks by an adult, she eventually showed some understanding of the routine and some willingness to help herself. Our experience with Gail, particularly at meal times, reassured us that such a setting was beneficial for even a severely disturbed child.

From a nutritional standpoint, we wanted to provide a lunch program that was high in protein, vitamins, and minerals. Limitations were imposed by budget, time and facilities. We had not originally requested funds for a food program and we therefore needed to buy groceries out of the limited "consumable supplies" funds. This limited us to about $5.00 per week or 25¢ per child per day. Our cooking facilities consisted of a two-burner hot plate, with the occasional use of an oven in the neighboring preschool unit; thus, menus needed to be largely of the "heat and serve" variety. The teacher had an undergraduate background in home economics as well as "subsistence level" budget experience in the Peace Corps and graduate school and these experiences proved valuable in menu planning. We planned a basic menu of one main protein dish, fresh fruit or vegetables, milk, and a nutritious dessert. By using such low cost protein sources as liver, hot dogs, tuna fish, eggs, cheese, hamburg, peanut butter, and lentils, we kept within our budget and offered a variety of simple dishes the children enjoyed. We bought whatever green and yellow vegetables were lowest in cost that week, used powdered milk, and took

advantage of store "specials." Soups were usually the creamed variety or some form of lentils. Large quantities of casserole were made and divided into meal-sized portions and frozen to be used later.

Desserts were usually fresh or canned fruit, jello or pudding which the children could help make. We discovered that more milk was consumed when a package of eggnog flavored instant breakfast was added to a quart of reconstituted dry milk. Several times we served waffles or pancakes as a main dish in combination with a vegetable salad and fruit dessert. This was a popular menu. For several children, the regular use of raw vegetables was a new experience. They were unfamiliar with such vegetables as green peppers, cucumbers, cabbage, cauliflower, radishes, and spinach. We tried to keep our meals low in carbohydrates since it appeared that the children received adequate amounts of those nutrients at home.

We tried to maintain a relaxed and enjoyable atmosphere at lunch. It was a time to just be "people" and converse in a relaxed setting. No one entered the area while we used it and we remained there until everyone was finished. We felt that this low keyed mood was important for the children to enjoy the food. Also, after lunch we usually moved into a music or literature period and a "group feeling" was one strong goal for this final period. In view of this social goal and the complexities of effectively supporting Vickie, Penny, Marvin, and Steve in particular, we eventually felt that only the basic core staff should eat with the children. During the year, two different child development students and two psychology students who had previously known Marvin, participated one day a week in a variety of ways. Initially they observed the class and then entered into a teaching assistant role for a limited amount of time.

While we viewed the lunch time as an easy activity in which to include them, we eventually reversed our decision. Lunch appears to be a vital part of the therapy process in which one of the most important ingredients is a relaxed, familiar staff who are well acquainted with each child's needs and current progress. It seems more advisable to let students and other visitors only observe via television at that time.

Techniques of Change

As we worked toward the goals set for our pupils, we relied heavily on sensitive observations of their behavior to assist us in planning. The psychologist often used Tuesdays as an opportunity to observe a particular child or type of interaction and then shared her suggestions with the teacher so the plans could be appropriately modified.

Each child presented unique problems which demanded individualized techniques even though we were attempting to make our therapeutic setting as much like a nursery school as possible. One of our original questions was to see whether children with a diversity of problems could learn from each other and enjoy the social interaction available. We feel that this question has definitely been answered in the affirmative. We felt that one of the greatest values of the experience was for the children to learn concern for each other. When Gail first entered the unit, for example, the other children stared at her quite a bit and were not certain what to do. When we began commenting on the small responses she did make and suggested ways they could help her, they shared some responsibility for her and accepted her easily.

The children soon divided themselves into two groups -- at least for the purposes of most nursery school activities. The division happened to be by sex. The boys, although differing individually a great deal, all seemed to operate with greater cognitive and physical skills. Their prime needs seemed to be for greater social skills. Marvin and Ronnie needed to develop more self-control, while Steve needed a greater sense of self. The girls had much poorer physical-motor development, unique language problems, a lack of normal "play skills" and creativity, and few effective social skills.

Considering these two distinct groups and the limits and opportunities of our physical facility, we divided the school day into five main components:

1. 10:30 - 11:15 Educational Therapy Period I
2. 11:15 - 12:00 Educational Therapy Period II
3. 12:00 - 12:30 Outdoor Activities
4. 12:30 - 1:00 Lunch
5. 1:00 - 1:30 Music & Rhythm Activities

The teacher was responsible for the music and rhythm period and the outdoor play. The two educational periods involved all the teachers and the children in planned variety. Even though we usually split the children by sex, we occasionally formed other groups. For example, we place Marvin with Vickie and Penny to encourage Marvin's empathy and concern and greater language use by the girls. As we learned more about the children, our goals became more specific, but the overriding objectives were greater independence, stronger sense of selfhood, expressiveness,

self control, and social development. While admittedly vague and general, the objectives became concrete in reference to individual children.

We used outdoor play, the lunch period, the music and rhythm period, and the bus rides as the settings for encouraging group feelings and communication. The adults tried to encourage this social learning in a number of different ways. If a child talked excitedly about something which really interested him, we suggested that he also share it with another child or the whole group. We sang and talked to each child as a way of giving others more information about him. We commented on the feelings in the group -- both negative and positive -- and asked the children questions like "What can we say?" or "How can we help?" We might say "Why do you think Ronnie was so sad outside?" and let them dance out some ideas. If a child was tired or sad or ill we might ask another child to help him in a special way.

We tried to encourage activities which demanded at least two children such as teetering, pulling wagons, swinging in the double swing, and moving large equipment. We also noted that while individual activities are very important for the development of a healthy self-concept, certain ones seemed to invite competitiveness more than others. Puzzles, easel painting, block building, tinker toys, and other construction materials seemed to more easily turn into "races" than did clay, play dough, woodworking, or fingerpaint activities. We speculated that an activity which demands a rather stereotyped response is more easily embellished with competition than one which is perhaps more open-ended and creative.

Whenever the question of racing and "Who won?" came up, we tried to discuss why they like to race and how both winners and losers feel.

Developing feelings of accomplishment was important to the ego development of the children. Throughout the year we tried to talk and act out our healthy respect for individual differences as well as our common interests or experiences. Thus, we might remind Marvin and Steve that they both had younger sisters at home; or that both liked trucks, etc. We talked about all the physical differences in the group as well as the similarities. Our total approach was to encourage socialization in the group as a combination of strong, healthy individuals.

With such a group of children, differing goals for individuals could be met simultaneously within one setting, as any good nursery school teacher recognizes. For example, in the first weeks of school, Steve needed to be in a setting where he could watch an activity without feeling too threatened. Ronnie and Marvin needed a lot of adult verbal reassurance and attention to develop their self confidence in the school setting. By working with Ronnie and Marvin together at a table while Steve was free to wander about and observe, both goals could be met. One of our most important goals initially was to help Steve move through the routine. Given our inexperience with the children and the busy traffic in and out of our section of the building, we did not feel we could let a child "do his thing" alone. Therefore we insisted that Steve move with us into the lunch room, that Vickie stay with us until everyone was finished eating. In retrospect, these limits seem important from a therapeutic standpoint. We felt that the human interaction and our growing understanding of each other was an important accomplishment of our program. To allow a child to leave at will was unsafe and in conflict with the group therapy goal.

Curriculum planning for the group was an interesting progression. For all the children, a great deal of the early weeks were spent learning about the other people in the program. What we played with was not as important as the ways we related to each other. Still, the ways they "settled in" were quite different, depending on their development. Initially, the boys seemed to need quite structured activities such as manipulative sets and games; but as they grew in self confidence and control, they made more decisions about their own actions and used such free expression materials as paint, clay, dough, lumber, wires, etc.

The girls had quite primitive play skills and were frustrated by structured activities. For them, the freer materials were a starting point which we used to help us assess their development and provide more appropriate materials. While eventually the boys were quite self-motivating and purposeful in their play, the girls continued to need intensive stimulation and support from the teachers. As a convenient way of summarizing, the original five categories of problem behavior initially identified and the corresponding guidance techniques and curriculum materials that seemed to be most successful for each will be presented.

I. <u>Withdrawing Behavior</u>

A. Guidance Techniques

1. With friendly, but firm manner, explain to the child what limits he is expected to follow. He should not be burdened with the feeling that the whole school is being changed for him, but he must have ample freedom within the basic rules that everyone follows. (For example, Steve had to remain in the lunch room, but could decide if he was going to sit down and eat.)

2. Note the activities and children with whom he seems most relaxed and provide identical sets of his favored curriculum materials for the other children in a neighboring area. This can be a first step toward his eventually entering cooperative play.

3. Keep a psychological place open for him in the entire group by mentioning his name in conversations, and by suggesting that other children ask him questions, offer a toy, etc. Indicate that you expect him to respond, but don't pressure him by waiting too long for a reply.

4. When he first begins to move into activities with other children, do not over react with enthusiasm or surprise. It may be important to quietly comment to one of the other children that you are both happy he has joined, but drawing a great deal of attention to these first attempts may discourage, frighten, or intimidate him.

5. Vary the schedule, setting, and regular activities from time to time to allow the child novel opportunities to enter group activities. We found it helpful to give enthusiastic special reasons for these changes so that it becomes an alluring opportunity.

B. Curriculum Material

1. In the beginning, try to have some duplicates of the child's favorite toys from home and make them easily accessible to him.

2. Provide puzzles, trucks, dolls or other very familiar toys which can be manipulated in familiar, rather stereotyped ways.

3. A variety of materials to play out themes of human relationships and family roles should be provided -- dolls, puppets, rubber or wooden figures, model houses, etc.

4. Provide less challenging opportunities such as coloring or puzzles, when the other children are engaged in such activities as finger paint, clay or dough, water play and other examples of very assertive play. The withdrawn child may thus color <u>beside</u> the painters and gain some sense of group participation.

5. Try to assess his developmental level and make certain the materials available are appropriate and will offer him satisfaction.

II. Hyperkinetic Behavior

A. Guidance Techniques

1. Set definite limits that are simple, logical, and frequently explained from the beginning of school.

2. Be energetically responsive both physically and verbally to the child's contributions. It is very difficult for such a child to receive a "blah" response from an adult.

3. Offer him intriguing opportunities for play and learning that really challenge him. Don't let him be bored.

4. Provide quite structured materials with much adult support in the beginning so that he can be helped to maintain self control. (e.g., a table activity may contribute more toward his self control than one which is spread out all over the floor) Gradually loosen the structure and encourage more choices as he develops self control.

5. Balance the program so that an opportunity for great physical release is balanced by a period of calming quiet -- preferably shared by the teachers and other children.

B. Curriculum Materials

1. Supportive-Structured:
puzzles, lego, tinker toys, erecto sets, books, terrariums, mini cars and trucks on a table landscape, lotto games, See Quees, easel painting, paper/glue collages, mini blocks, planting in seed cups, block printing, aquarium.

2. Releasing-Active
large blocks and props, punching bag, tumbling mat, slide, jumping platform, water play, dramatic play--store, firemen, post office, house play, nature/adventure walks, gardening outside, beans or sand in manipulative settings, painting on wall--huge paper or cardboard, finger or toe painting, clay or play dough, work bench and carpentry, wire and plastic art, salt painting, soap painting, musical instruments, live animals--cats, frogs, dogs, etc., puppets.

III. Immature Behavior

A. Guidance Techniques

1. Help the child succeed from the beginning. Provide simpler materials in the first weeks of school, then progressively more difficult ones. Intercede with support and encouragement when he seems ready to quit.

2. Make the rules simple and understandable to him from the beginning.

3. Accept and plan for his great need for solitary and parallel play. Gradually encourage cooperative play around tasks which need more than one person to be accomplished.

4. Provide curriculum materials which contain inherent closure and satisfactions such as puzzles and lotto games. We suggest that the immature child is confused by activities that seem to have no real beginning or end.

5. Encourage his self-ordering of tasks such as cleanup decisions, organization in block play, etc.

6. From the start, encourage him to talk out his feelings and verbalize possible solutions to his problems. (e.g., "That makes you feel little when we can't move that, doesn't it? How could we move it together?")

B. Curriculum Materials

1. Stringing large beads or noodles (which has inherent order and discipline).

2. Puzzles, form boards, lotto games, which are appropriate for his ability.

3. Work bench -- soft lumber and slim nails with large heads to help him succeed. Fiberboard and styrofoam can be used with instant successes in the beginning. Use real tools, but in the smallest sizes.

4. Easel painting with thick, non-dripping paint. The immature child seems to gain satisfaction out of finishing a picture.

5. Finger painting in a tray.

6. Collages -- especially with pictures of people or things that he likes.

7. Cooking projects -- soup, cookies, cupcakes, salad, sandwiches, pizza, etc. (Provides a sense of closure and self confidence about making your own food).

8. Drums, chimes, cymbals and other "do your own" musical instruments.

9. Punch bag and bean bags with large targets.

IV. Poorly Coordinated Behavior

A. Guidance Techniques

1. Encourage self-help. Wait for the child to try, say, "I'll help you learn how," or, "we can do it together now and later you'll be able to do it all alone." The times when self-help is particularly important (in and out of vehicles, toileting, washing hands and face, dressing, feeding) are often transition points for the school and full of some confusion and stress. Plans must be developed to start the poorly coordinated child early and allow him more time than the other children.

2. Participate in vigorous physical activities with the child. Identify the activity units so that the child can recognize and experience them as enjoyable proud accomplishments.

3. Conduct detailed conferences with parents about tasks being stressed in school. Give parents specific demonstrations of how to help their child be more independent.

B. Curriculum Materials

1. Small Muscle Use:

Beads and noodles for stringing; nesting barrels or other toys which twist to open; pop-it beads; puzzles; form boards; beans to manipulate; play dough with silverware and small cookie cutters; sorting games; doll clothes for buttoning, snapping and zippering; paint with small brushes; eye droppers to use in water play, mini blocks and cars; small brushes and fabric for pasting, paper, noodles, cereal, etc.

2. Small and Large Muscle Use

Chalk for drawing on table or wall; finger paint, play dough or clay with rolling pin and cooking dishes; table, pitchers, trucks, things to pour and open or close; doll buggie and wagon play; piano; triangle; water play with egg beater; funnels; dolls and pitchers.

3. Large Muscles

Balance beam; stairs; inclined plane; slide; tumbling mat; ladders; obstacle courses; punch bag; balls; food preparation for stirring and grinding; rocking boat; teeter totter; song-rhythm dances and games; inner tube for jumping and crawling; swings; trikes and other outdoor equipment.

V. Non-Verbal Behavior

A. Guidance Techniques

1. Language modeling: maintain a high level of verbal stimulation during play, particularly in response to the child's interests.

2. Participate with the child in active play and share the appropriate language as you enjoy the activity.

3. Arrange social interaction with more verbal children on swing, teeter, and with wagons, throwing balls, circle games, rocking boat.

4. Use a great deal of physical contact -- hugging, running, teasing, swinging by the arms, swinging on your lap. Start the human communication in loving, physical ways.

5. Once a child uses some word or phrase, structure other activities where the words can be appropriately used again.

6. Offer open-ended activities which allow the child to act and then can provide the words to accompany action. This is particularly necessary when it is difficult to assess how much language the child can comprehend. (For example, #4 below.)

B. Curriculum Materials

1. Music and dance can be employed to illustrate simple words and concepts like high and low, fast and slow, big and little, in and out, etc.

2. Cooking projects that allow the repetition of simple commands like "stir," "cut," "pour," etc.

3. Doll play with words and sentences common to family situations.

4. Water play with a small selection of props whose names you use in conversation.

5. Puzzles with which instructions can be repeated many times, "Where does this go?" and "It is finished!"

6. Play dough and clay with a variety of props (perhaps the same ones used in doll play or water play to repeat the words). Describe in words what the child is doing, "Oh, you rolled it!", "Squeeze it", etc.

7. Slide, swings, bikes, teeter totter, wagons with which you use common terms like up-down, back-forth, around, push, pull, etc.

8. Play or real telephones

9. Puppets and dolls

All of the recommended techniques reflect the particular problems of our children, but some attempt has been made to generalize them. From the repetition of activities in various lists, it can be seen how several children might use one activity for different goals. We usually worked with the boys in a group, but tried to give each of the girls at least two individual sessions per week.

Follow-Up Activities

As a final note, relating to techniques of change, we feel it is very important to the continued progress of the children that the staff be able to spend some time next year with the children's new teachers. In order for their entrance into another program be as smooth as possible, the new teachers will need specific information about techniques and support for their efforts. We do not feel that a complete case study should be shared, but rather encourage the belief that a sensitive teacher can be crucial for each child's success. Other mental health workers seem to agree that this supportive, optimistic approach can help both the child, the family, and the teacher.

Mother Contacts

Each mother was visited in her home by the teacher or the psychologist or both (together or separately) before the child entered school. After school began, mothers made one or more one hour visits at school. From the beginning, it was made clear that all mothers were expected to participate at school on a regular basis, but that this would follow the first weeks in school when the children's adjustment would be the primary concern. During these first weeks we contacted all mothers several times by phone or made additional home visits.

After one or two visits alone at school -- about two to three weeks apart -- four mothers were scheduled to visit in pairs every two weeks. The fifth mother continued to be in contact through regular phone conversations with the teacher. It was her choice, and ours as well, that she allow her dependent child the free opportunity to make progress on his own. She and her husband did visit during the last weeks of school. The sixth mother was not included in this program, although she might have been brought in on a limited basis had her child been in the program longer. All mothers' attendance was considered as a requirement and they were assigned monthly dates. They were reminded individually by both the bus driver and a phone call on the day before their visit. They were free to travel on the school bus and they brought their own lunch.

A typical schedule for two mothers was as follows:

10:30 Mother #1 visits with the psychologist while mother #2 observes a play activity with her child, an activity specifically designed to demonstrate some method of adult-child experience for her. Mother #2 may sometimes be given special directions on what to look for in the activity. For example, the mother of a child with communication problems might observe the teacher

working with her child in a setting we knew would elicit language and conversation with teacher help, perhaps water play or the dollhouse or puppets.

11:15 Mother #2 may be instructed to enter the play area in some specific manner, again with an activity planned for the occasion. For example, on several occasions a creative activity such as finger painting was set up to help a mother relax and enjoy her child without pressuring him to be perfect.

The staff adult working with the child planned on occasion to give special directions to the mother on the scene (mothers were forewarned to expect this). For example, one mother used threats to get the child to do what she wanted. The teacher asked her to work with the child in a more constructive way, telling her what to say to get the child to work independently. This was not easy for mothers, and the teacher used tact, but it brought home points in a direct manner and mothers commented on how it reached them.

Meanwhile at this hour the psychologist might work with mother #1 by observing a specifically planned activity.

12:00 Mother #1 goes outdoors for play period with the children. Mother #2 has finished observation and participation and now meets with the psychologist.

12:30 Both mothers and psychologist eat lunch together. The mothers had been paired to be most helpful to each other. By this time the psychologist usually took a less formal role with both. Luncheon discussions were both spontaneous and planned. They covered such topics as problems mothers had in common with their own parents or siblings, or the pain that goes with having a child that is "different." During the last weeks such topics as school enrollment or summer plans were foremost. If these discussions were particularly fruitful they extended up to 1:30. Generally, when they came to a natural end mothers were invited to join in the group activity and participate with their child again.

During the last month we were able to introduce another variation for mothers. While the children ate lunch, mothers observed them via closed circuit television. This was a very useful method and may be expanded next year. Since we did not have a soundproof observation booth, this method allowed for more free discussion between parents and psychologist.

More needs to be said here about the content of the time which the mothers spent with the psychologist alone. The psychologist was perceived by the mothers as a sort of family helper. Although the psychologist was trained in psychotherapy, no mother was committed to treatment for herself. The focus was on the child in school and on related parent-child interaction. Each visit was preceded the day before by consultation with the teacher in which the current needs of the child were assessed and topics to work on with mothers were selected. Since the psychologist spent some time on the preceding day observing the children, these needs were generally mutually clear. The issues to be discussed were almost always tied to the mother's time with observed activities and participation. On several occasions spontaneous behavioral situations erupted (such as a full blown discipline problem) which were extremely useful.

In some cases these discussions turned naturally to the more personal needs of the mothers in relation to their child. One problem that came out for several mothers was intrafamily relationships which made difficult demands on the mothers and encouraged the child's pathology. In one case the mother responded to all our comments about her child's needs by saying, "That's just like me" or "I know he gets that from me." To deal with the child's needs led inevitably to the need to deal with the mother's problems. For all mothers, the issue of their feelings about the atypical behavior of their child was explored.

The days set aside for parent visits to school were often trying. The teacher and her staff were under pressure to do their job well. All children reacted to the day of their own mother's visit with some increase in tension, distractibility and/or infantile behavior, even when the mothers

were not actually present in the room. This change placed an added stress on the staff and on other children. In some cases the mother's schedule had to be planned to allow the child a breather -- as for example, one mother never went outdoors after an initial visit when the strain on the child was too great. It was our conclusion from this initial experience with five children and their mothers that the benefits of the bi-weekly visits were sufficient to continue with this pattern, but that more frequent visits would be detrimental to the progress of the children. We are eager to experiment with the use of videotape. This might allow for even less disruption of the class by parents and allow more selective observations.

Four months after school started, when we were assured of full participation, an evening parent meeting was scheduled. All six mothers and one courageous father attended. The format was not highly original, but we present it here because it did prove to be a useful way to bring them together with their common needs.

The meeting began with everyone mixing play dough to take home for their children. This activity helped to break the ice for the parents and all seven of them warmed up in the process. It was also a useful tool for increasing our understanding of them in a more active setting. (For example, the mother of the child who refused all gooey activities had considerable difficulty working actively with the material.) While parents worked, they exchanged ideas with the teacher and psychologist about how their children could use the play dough to meet their individual needs.

After this activity we adjourned to another room for coffee and cookies (made by a mother who wanted to serve us in this manner). Since the children's books were there, the teacher discussed a few specifically relevant books. She told what each child liked in books and how he or she could respond to stories or even just pictures. Parents asked questions and added their observations.

In this relaxed setting we attempted to open up a group discussion of their feelings about being parents of atypical children in a special class. Comments ranged from heartfelt appreciation to despair over neighborhood complaints that a child was "nuts," or feelings of inadequacy when a child cannot behave normally in public. All parents participated, and from their comments and their behavior we learned much about them, just as they benefitted from self expression and from each other.

Future Placement

In our early discussions of the therapeutic unit we perceived our role primarily in terms of behavior change for children and parents. As the year drew to a close, we found ourselves in another related but somewhat different position. Parents and agencies were asking "What next?" We needed to help answer these questions in two ways:

1. Diagnosis -- In order to make recommendations for programs beyond the confines of our class it became necessary to pin down some specific information about the children that would determine their eligibility in one program or another.

2. Planning for future placement -- Many communities do <u>not</u> reach out to these children with a myriad of services! Parents and interested helpers must assess the resources of the community together with the child and his needs and battle for appropriate placement.

Our program did not include formal diagnostic evaluation. Pressures for placement did, however, necessitate the consideration of such evaluations using either standardized measures or intensive observation. Some of the issues made it clear that for our group one of our major contributions to the development of the child was the five months of behavioral observation which could then serve in making helpful suggestions and decisions.

The first consideration was whether or not the child was ready for public kindergarten. Five of the six children were old enough to attend, but only two were capable. For these two children the major concern was that they be placed with mature teachers who could continue their development and handle their behavior. Both their mothers were encouraged to assess their schools and deal with this issue. One mother had pre-selected one of the two available teachers and presented her thoughts to the principal. He concurred, and the outlook for the child is hopeful. The other mother was unable to mobilize herself to take such action (she herself was a school drop-out). We then checked with the school nurse who handled this case, and learned that one teacher was not recommended and the other not yet appointed. We can only hope for appropriate follow-up. We were able, however, to shift our responsibility to the school nurse who can call on us as needed.

For those children who could not attend public kindergarten the path was much less clear. One looked as if he might be able to enter kindergarten after another pre-school year, preferably with a normal group. This same child also gave some indications that he might have a hearing problem. Therefore, at the same time that we were making the decision

regarding future placement, we were also observing him very closely for signs of hearing loss. Since he did sometimes hear soft voices we finally concluded that he had difficulty attending to stimuli from different modalities at the same time. This seemed to fit in with his other difficulties with integrated physical functioning. Finding the appropriate placement was another story. He is now on the waiting list of half a dozen nursery groups, none of which we were able to contact or visit since they are located far from our facility.

Another child needed a normal pre-school group -- not as a stepping stone to kindergarten, but as a stimulus to development. It was decided to seek out such a program as a part of the therapy for the five-year-old autistic child. Procuring this placement involved finding a teacher who could handle the child and a school that would accept such an arrangement. The teacher visited our facility while our psychologist visited her class and spoke to the school board. Acceptance there is only the beginning. Consultation and supportive services such as student teachers and volunteer helpers will probably be needed. Fortunately the child's therapy team can take over these responsibilities.

The last child presented the greatest diagnostic problem. This was the child who had been referred to us by the center for moderately retarded children as too capable for their classes. We attempted to place the child in a local school for physically handicapped children, but without success. We then arranged for an intellectual assessment. This assessment did indeed place her at the upper limits for the center from which she had been referred, but also below successful placement in either kindergarten or local educational programs for slow learners.

The mother was interested in trying a day care placement, and had indicated this even before formal assessment had taken place. The parents were informed of the assessment results by the psychologist and the day care placement was encouraged. It was our opinion that she could function with the younger children in a day care center and that her development could be further assessed in that setting. Probably this child will need to enroll in the program for the retarded when she enters public school, and preliminary arrangements for this contingency have been made.

One facet of our future commitment to these children relates to the need to observe the permanence of changes made in the therapeutic program. It is not enough to be satisfied with progress in a very protected setting. This progress must fit in with the future placement and development of the child. Whether or not we should attempt to make such follow-up a part of a formal evaluation of services may depend on our experiences in the next year as we check into the progress these five children make in their new settings.

APPENDIX

Behavior Rating Scale

BEHAVIOR RATING SCALE

Head Start Research Center
Michigan State University

INSTRUCTIONS

Please rate all of the children in your class on the five scales attached here.

Take your class list and look at the first scale. In a class of 15 or 16 you would expect to find about 2-3 children in the low category, 3-4 in the medium low category, 5-6 in the medium high category and about 4 in the high category. Since no two classes are alike, these numbers are only a suggestion. Your class may vary somewhat from this pattern.

Read the description of behavior at the top of the page. Below you will find spaces for the names of all the children in your class. Place each name in one of the boxes on this first scale. Since this class is new to you, you may find this is difficult to do. However, even when you are not sure, place each child to the best of your ability.

Now turn to the next scale. Again read the description and assign the whole class to one box or another. Continue in this manner through all five scales.

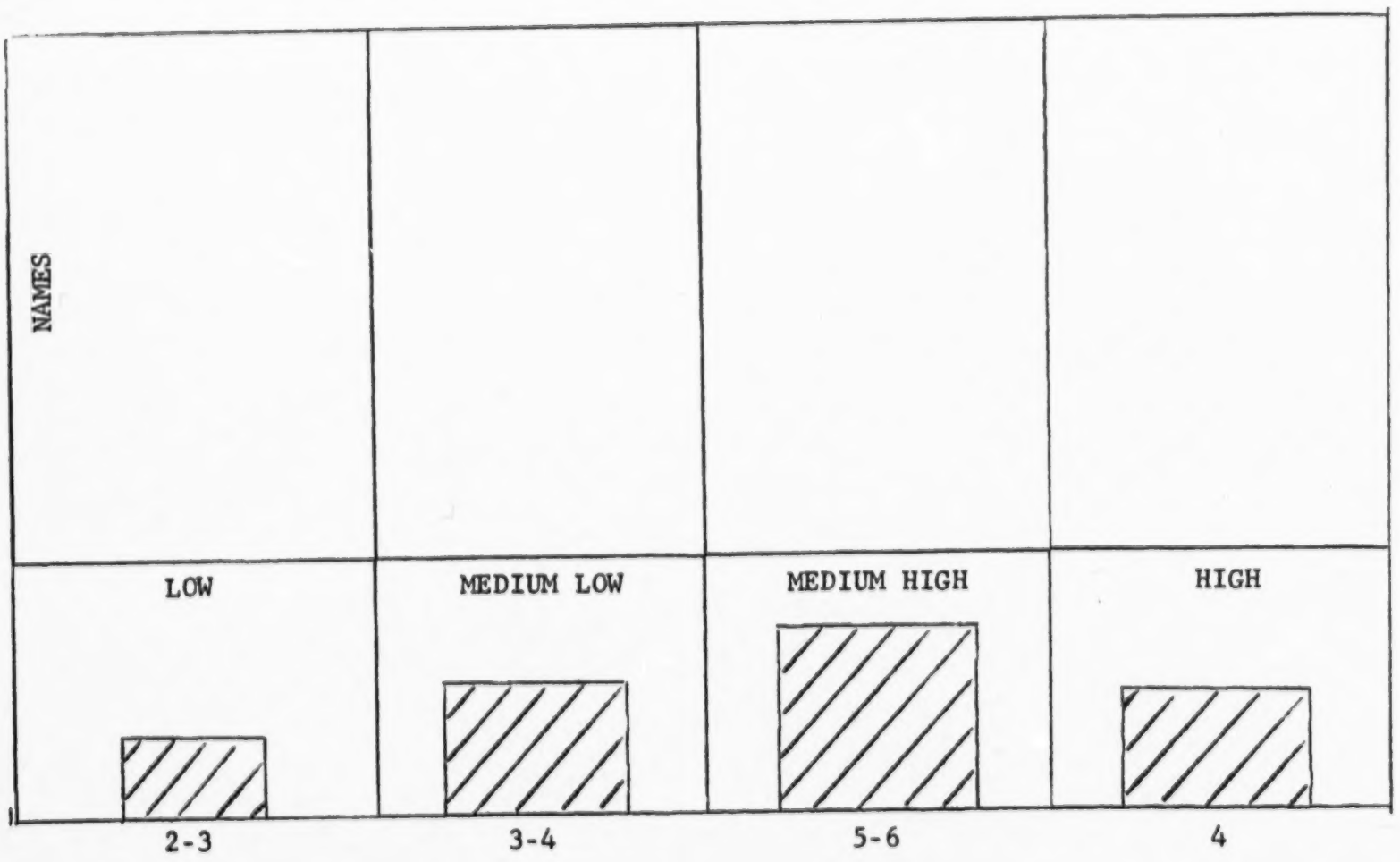
School_____ Location _____

Teacher_____ No. of pupils enrolled_____

PHYSICAL COORDINATION

Low: The child who is low on this characteristic is unusually clumsy. He may fall all over himself and others. His eye hand coordination may be poor so that he has difficulty manipulating crayons, eating without spilling, taking part in games. He may seem to be forever into minor accidents resulting in bumps and bruises.

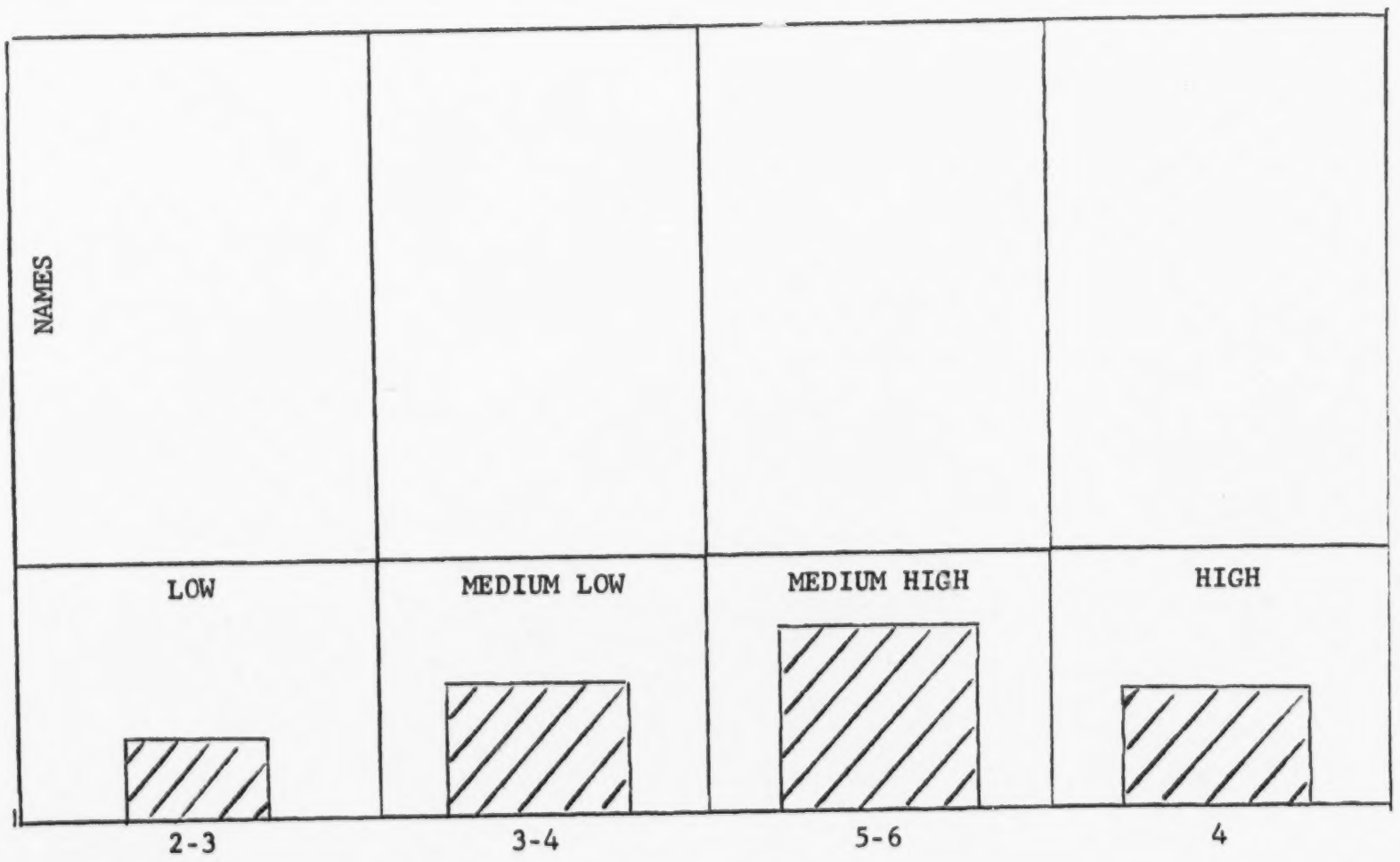
High: The child who is high on this characteristic gets around easily. He can manipulate materials (crayons, puzzles, etc.) with ease, and will enter successfully into games. His mealtime habbits are neat.



INDEPENDENCE

Low: This is the child who clings to you constantly. He does not seem to be able to proceed to any activity without reassurance. He refuses to take on simple responsibilities that you know he could perform. He demands so much of your attention that you find it difficult to give others appropriate attention.

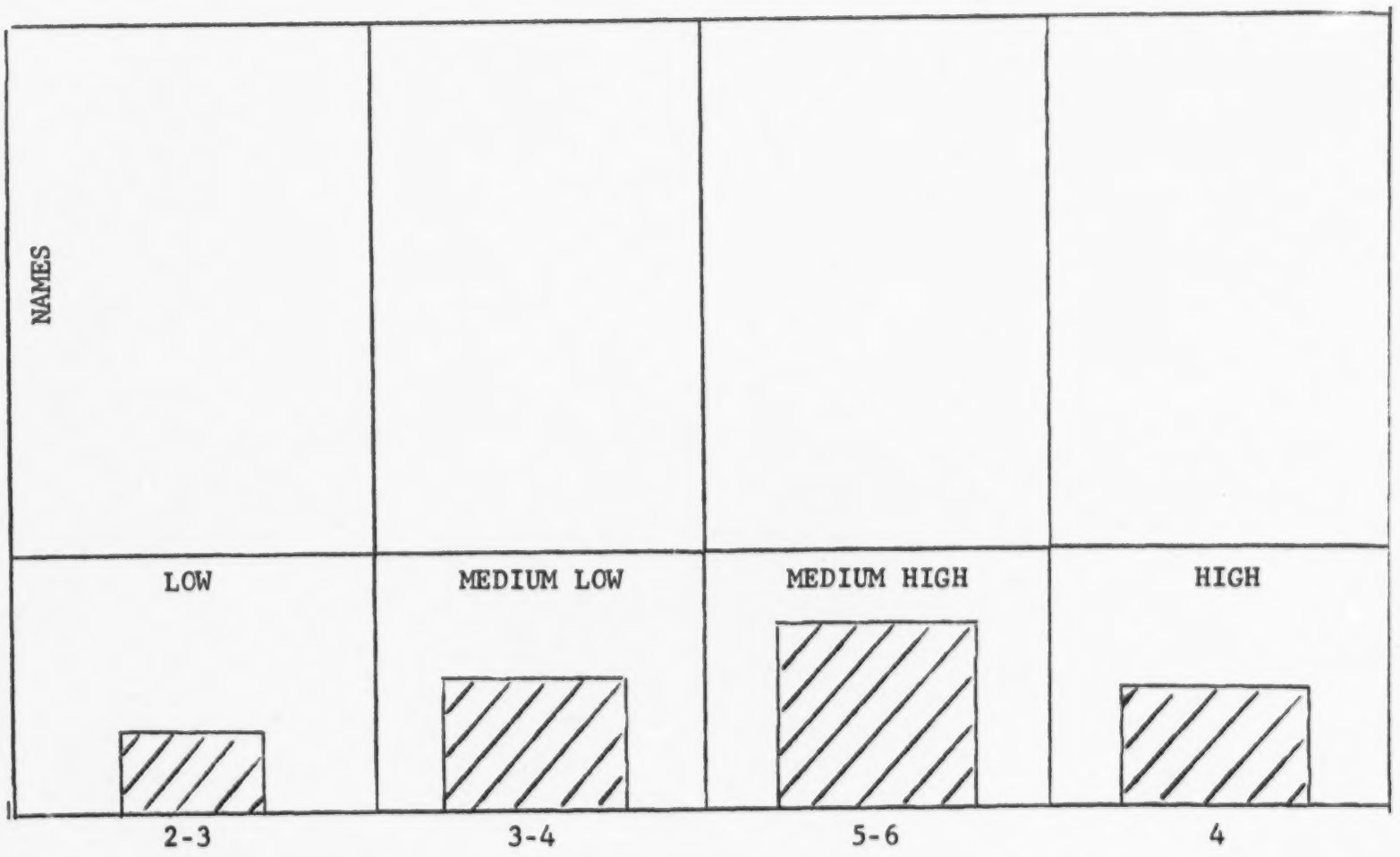
High: This child is able to go ahead and do things on his own. He rarely requests help unless it is a real need. He functions on his own without extra attention from you or others in the room.



SELF-CONTROL

Low: This is the child who gets excited easily and cannot sit still. He gets angry and hits out at others quickly and with little provocation. He creates enough commotion and chaos that he may break up an activity with you and the other children.

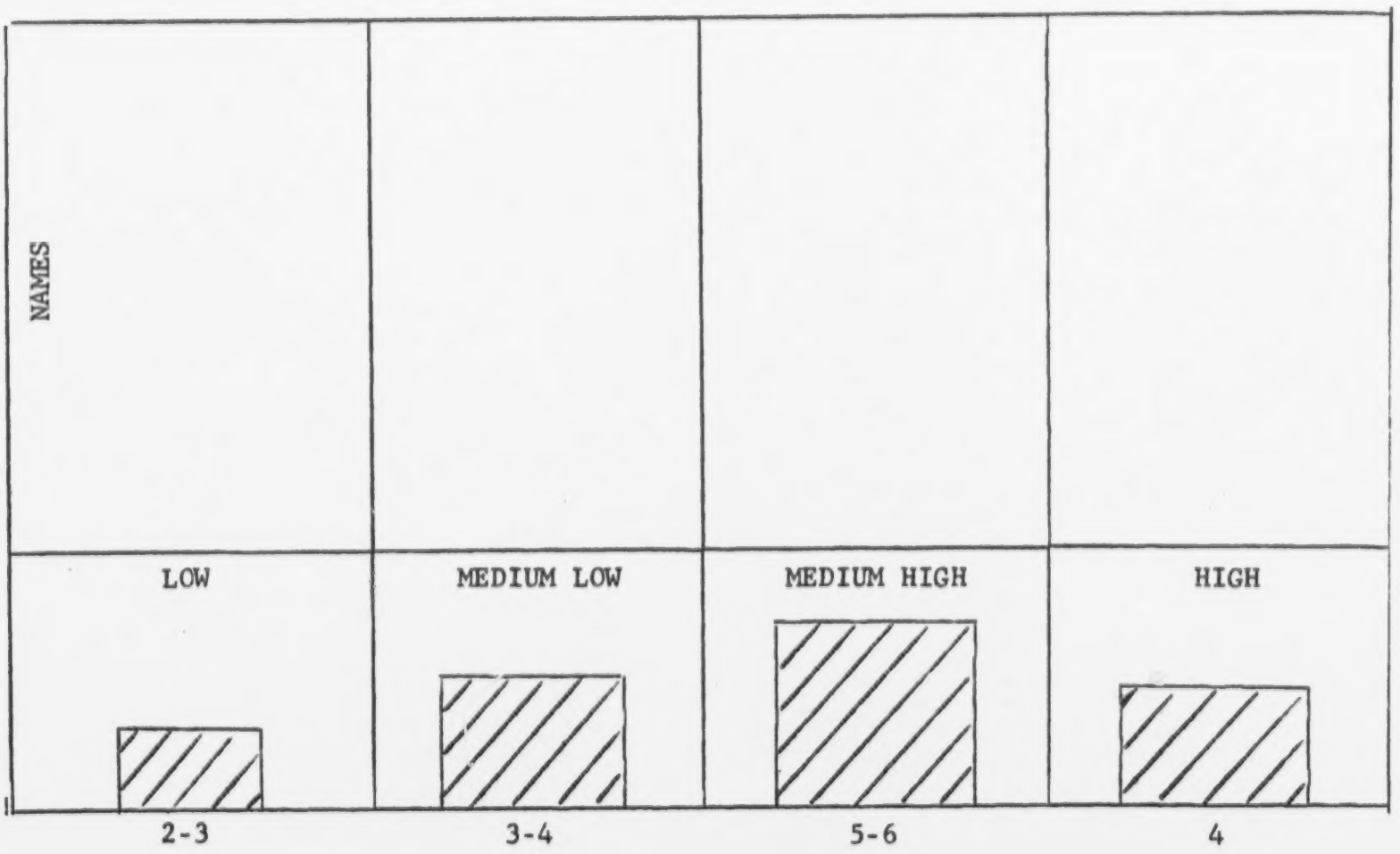
High: This child can join in the group and sit still, following the activity of the moment. While he may get angry when it is appropriate, he also follows rules and controls his behavior.



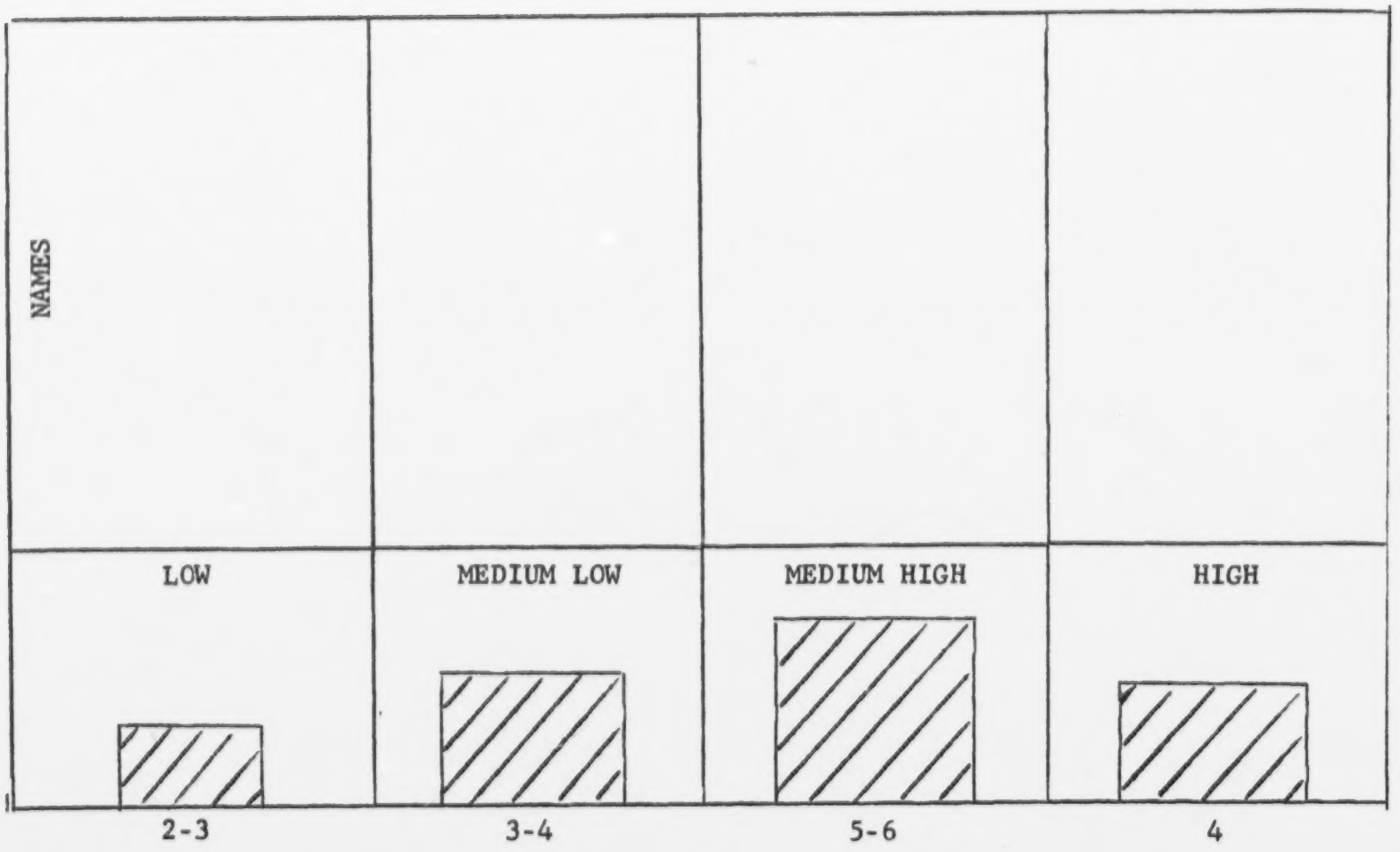
SOCIABILITY

Low: This is the child who is shy and does not seem to get involved in class activities. He may watch from the sidelines or play alone. He may seem to be dreaming in a world of his own that cuts him off from routine activities.

High: This child enters enthusiastically into group activities. He plays well with other children and children like to play with him. He plays with groups of children rather than alone, and may act as a group leader. He participates readily in group discussions.



ABILITY TO TALK

Low: This is a child who is immature in language development although he appears to be of normal intelligence. He talks in sentences of 2-3 words, or less. He may not know his name. He cannot ask for what he wants. When you attempt to converse with him or draw him into class discussion, he seems lost and unable to function.

High: This is the child who talks easily and uses sentences in an understandable way. He can carry on a conversation with you or contribute to the group by talking about a topic at hand. He can make his wants known in words and does so.